

# THE MEDICAL EXAMINER

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### ORIGINAL COMMUNICATIONS.

*Case of cellulo-vascular and fibrous Polypus occurring simultaneously; removal of both by the ligature.* By JOHN F. MEIGS, M. D., Lecturer on Midwifery, &c., in the Philadelphia Medical Association.

Mrs. J. F. the subject of the following case, is an Irish woman about forty years of age. She is the mother of several children. Her last pregnancy terminated in a miscarriage on the 24th of April, 1843. About the end of the year 1843, or the beginning of 1844, (she cannot recollect which), she began to be subject to violent and frequently repeated attacks of uterine hemorrhage, which exhausted her very much.

I was first called to see her on the 20th of January, 1845. She had then been flooding very badly for several days, and was extremely weak; she had fainted several times, and seemed almost exsanguinous; she had been under the charge of several physicians, by whom she had been treated with various astringent remedies.

I made a vaginal examination at once, and found two polypi growing from the cervix uteri; one was about two inches long, pyriform in shape, with a base about an inch and a half wide, rapidly narrowing to a small slender pedicle, which was attached to the cavity of the cervix uteri; this one was soft and yielding to the touch. The other tumour was much larger, and grew from the posterior lip of the os uteri; it seemed indeed to be entirely a production of that lip. The shape was pyriform like that of the

other, but the pedicle was much larger in proportion, and the whole tumour seemed to be about twice as large. Its consistence was entirely different; it was hard, resisting and somewhat elastic to the touch; it had in fact all the characters of a hard, fibrous polypus. It was about as large as a full sized butter pear, while the smaller one was rather less than a well-grown catherine pear.

On the 22d of January, 1845, aided by Dr. Mason of this city, I passed a ligature, by means of Gooch's double canula, around the pedicle of the smaller polypus. It was somewhat difficult to adjust the loop, in consequence of the presence of the second tumour in the vagina, but after a little patient manipulation, I succeeded in fixing it high up about the pedicle. On tightening the ligature the polypus fell off; it proved to be a cellulo-vascular polypus; no hemorrhage followed its separation, and the patient did not complain of any pain.

It was thought best not to operate upon the second tumour for some time. The patient was for several weeks in a very critical situation; she had symptoms of peritoneal inflammation, which however yielded to very simple treatment. After this she was attacked with fever of a low type, which resulted at last in an extensive purulent collection over the posterior surface of the sacrum. This was opened, and she gradually regained a pretty good state of health; she regained strength enough to go about the house and attend to the cares of her family.

She had some slight attacks of hemorrhage in the latter part of 1845, and in the early months of the present year.

Sometime in May of the present year, she was seized with a most violent flooding, which for some time exposed her life to great danger. After this I requested Dr. Hodge to visit her with me, in order to determine upon the propriety of removing the large polypus, which had increased very much in size. At this time it filled the whole cavity of the vagina, and during the efforts of defecation and urination, frequently passed partly through the vulva. Having agreed upon the operation, I proceeded to perform it, with the aid of my friend, Dr. William Keating, who also assisted me in the after treatment of the case.

Thursday, June 11th, 1846,—At 5 o'clock P. M., I applied, by means of Gooch's double canula, a large strong ligature of twisted silk around the pedicle of the tumour, at the distance of about a quarter of an inch from the cervix uteri. As the tumour grew from the whole of the posterior lip of the os uteri, I was careful not to include any portion of the substance of the uterus in the grasp of the ligature. The ligature was drawn as tightly at the time as it could be drawn, and then carefully secured. It gave but little pain. The patient was desired to lie chiefly on her side, and to be as quiet as possible. As she was very much ex-



hausted from her frequent attacks of hemorrhage, she was allowed to take pretty freely of light, nutritious diet, and from time to time she took small quantities of milk punch. She was to have an opiate in the evening.

As no bad symptoms occurred, the ligature was tightened every day. In three or four days, the discharge from the vagina became very offensive, and on tightening the ligature, it was evident that it cut through a portion of softened tissue.

No bad symptoms arose for several days, except the occurrence of violent abdominal pain, with some tympany and soreness to the touch, on one occasion, after the ligature had been drawn very tight. These symptoms, however, disappeared after loosening the instrument a little, and left no bad consequences.

On Saturday, the 20th, there was inability to discharge the urine. The difficulty seemed to depend upon the pressure of the instrument and the tumour upon the urethra. The tumour had increased very much in size, so as to fill and distend the whole of the vagina. The external parts were very much swelled and irritated, and they as well as the vagina had become painful to the touch. The catheter was introduced with some little difficulty, room being obtained by pushing the canula backwards towards the perineum. The catheter was used on the 20th, 21st and 22d.

On Sunday, June 21st, ten days after the application of the ligature, the tumour was forced through the vulva, during some effort the patient was making. It was about as large as a large ostrich egg. Its external surface was rough and uneven, and of a deep red colour. It was hard and fibrous to the feel, and looked very much indeed like a piece of coarse flesh. The pedicle, which was closely embraced by the ligature, was not more than two or three lines in thickness. As it gave the patient no greater inconvenience in its present situation than it did before it was protruded, it was allowed to remain.

At a little after two o'clock, on Monday the 22d, the tumour fell off from its attachments, the separation taking place about half an inch above the point embraced by the ligature. The ligature with the canula remained fastened upon the tumour. The ligature had remained, therefore, very nearly eleven days, before the vitality of the polypus was sufficiently destroyed to cause it to drop off.

The polypus upon examination, proved to be very large. It was between four and five inches long, by three or four broad. It would about fill a large ostrich egg. It was fleshy in consistence, of a sanguine red colour, rough upon the surface, of homogeneous texture, without any cavity, and presented in fact all the characteristics of a hard, fibrous polypus.

The patient was weak and fatigued from the constraint and irritation she had undergone during the operation of the ligature, but had no other bad symptoms.

July 2d, 1846.—She has had no trouble since the separation of the polypus, so far as regards the pelvic organs, with the exception of slight ardor urinæ. Her command over the bladder is perfect. The bowels act well, and she has had no symptoms of inflammation of the uterus, ovaries or peritoneum.

She has had for a week past some teasing cough, with a little hectic irritation. She complains of aching, erratic pains affecting the left side of the thorax. There is some dulness of percussion over the lower third of the left lung, behind, with feeble respiratory murmur, and slight crepitus after coughing. The expectoration, which is small in quantity, is of thick colourless mucus. She is to take a few grains of iodide of potassium in compound syrup of sarsaparilla, three times a day, and to have a Burgundy pitch plaster applied to the side.

On making a vaginal examination I found the shape of the os uteri well preserved. The direction of the opening is transverse, and its width about an inch. The margin of the vaginal portion of the cervix is very well marked; even the posterior lip itself retains its proper form, with the exception of a slight irregularity. The whole of the cervix uteri was swelled, and felt much harder than in the ordinary condition, though there was nothing like scirrhus hardness or irregularity that I could detect.

As she was able now to move about her room a little, and seemed to be contending only with weakness and the pleuritic affection, we recommended her to go to the country for a short time to recruit.

Early in August, after she had been two weeks in the country, I saw her again. She had recovered, in a great degree, good health. She had become quite strong; went freely about the house, had a good appetite, had lost all her pulmonary symptoms, was fast losing the anemic look which had so long set its mark upon her, and was in fact restored apparently to good health. She had not had, at any time since the operation, any symptoms of disease of the reproductive organs.



## BIBLIOGRAPHICAL NOTICES.

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*The Structure and Functions of the Female Breast, as they relate to its Health, Derangement and Disease.* By E. W. TUSON, F. R. S., F. L. S., Surgeon to the Middlesex Hospital. 8vo. pp. 485. London: 1846.

This is a singular production from one holding so prominent a post as Surgeon to one of the London Hospitals; who is withal an F. R. S., and F. L. S., and who, it seems, has already appeared *six times*—

“Insatiate Tuson! could not *once* suffice”?—

before the public, and from whom, he says, he has already experienced “liberality.” To the profession, however, he is not very complimentary, for they do not appear to uphold him in certain of his—what appear to us—empirical propositions.

“In introducing new remedies,” he says, “many difficulties have presented themselves, which I must own could have been little anticipated, particularly amongst members who fancy themselves branches [?] of a liberal profession, who on many occasions have been pleased to term my endeavour to advance the practice of medicine ‘Quackery,’ for giving those remedies of which I knew not the dose or effects.” p. xiii.

Most certainly does the charge of quackery appear to us to apply to him for many of his remedies proposed in the present volume; yet they are not all recommended without some vague hypothesis being stated as the rule of conduct, of which the following may be regarded as a specimen:

“We are indebted to Mulder for the discovery of proteine and its compounds; and Scherer analyzed this original matter prepared from animal albumen and fibrine, from the crystalline lens, from hair, and from horn, and the results of all these analyses agreed with the formula  $C_{48} H_{36} N_6 O_{14}$ , which is about identical with the blood in the healthy state. From a variety of practical observations, made during a period of nearly twenty-five years, a great portion of this time [?] having been devoted to the bed-side of the patient, I have been frequently struck

with the want of power in the system to enable the constitution to bear up against disease [! !]; and as proteine entered into the formation of several of the tissues (being identical with blood) of the frame," [we do not see the *sequitur*,] "I was led to investigate its effects upon the system. I found it beneficial in repairing certain decayed structures," [of what kind?] "in assisting the functions of nature in producing certain portions of the animal frame, which had become weakened from a want of solidity; and under various circumstances attendant with debility. Its use became serviceable. The preparation was made according to the directions given in Turner's chemistry, and the results will be seen in these pages. But since that time Baron Liebig's researches have tended to disprove the existence of proteine: we must therefore call it by some other name. It has been administered in numerous instances; and a something can be procured which has been beneficial, and will be so in future: therefore, until we have a fresh term for this original matter, we must be at present satisfied by calling it 'proteine.'" p. xv.

This is a sample of the author's therapeutical reasoning, and it is one of the best. He is evidently one of the chemical school of Liebig, but does not appear to possess much of the spirit of his great leader,—from whom, by the way, he extracts in a wholesale manner.

"Chemistry," he says, "has far exceeded in discoveries our practical knowledge of the effect of medicine; and if we consult any work on that subject, we must be struck with the number of new preparations that are described, and which have never been used in our practice: their actions are still unknown; so that the greatest benefits may hereafter result from the exhibition of many of these productions. Chemistry has enabled us to understand the composition of several parts of the animal frame; and in these pages I have had occasion to point out that certain parts of the body possess particular chemical properties. Thus the brain and spinal marrow have entering into their formation certain acids and products, which are not present in other structures, and which are perfectly distinct from other animal tissues. I [?] have pointed out that brain and nervous matter contain cerebrie acid, oleo-phosphoric acid, cholesterine, &c. May not some diseases of the brain and nervous



system depend upon a deficiency or an excess of one or more of these chemical constituents? When urea abounds in the system, we know the consequence—the brain becomes affected and the patient dies. May not the stomach cause a greater quantity of these acids to exist? and may not this be the cause of certain affections of the mind and nervous system?—or may not the stomach be deficient in supplying these chemical agents which may be essentially necessary to health? What effect would these products have upon the constitution, and upon certain diseases of the brain and nervous system? What effect would cerebrie acid have in certain deranged states of the mind? What effect oleo-phosphoric acid? These are questions that I am not at present prepared to answer, but in a short time hope to be able to place before the public some interesting particulars on this and on other points.” p. xi.

These “interesting particulars” we are satisfied, will never come; and the suggestions themselves can only be regarded as gratuitous. When the views of Liebig in regard to the constitution of the encephalic neurine were first published, we ventured to affirm publicly, that some wiseacre would be sure to ascribe disease of the encephalon to an excess or defect of one or more of the essential constituents; and it was not long before we heard of a physician prescribing phosphorus to a nervous lady on the vague supposition that the malady might be owing to a defect in the proportion of phosphorus;—as if disease did not always consist rather in mal-assimilation, than in deficiency of pabulum. From Mr. Tuson’s researches, we confess we are amongst the “blessed” who expect nothing. Notwithstanding his pretensions, his acquaintance with chemical science is evidently by no means profound; and at times his chemical reasoning borders absolutely on the ridiculous.

The Author commences his work with an “anatomical examination into the structure and functions of the mammary glands,” in which we are told sundry facts that are new to us:—for example, that “the period of *maturity* commences at puberty, and ends about the forty-fifth or fiftieth year.” During the ‘age of youth,’ “the pelvic viscera and *mammæ* are rapidly developed; the hips become enlarged; the thoracic viscera *expand, increasing the mammæ*” [!]. Each *lobe* of the breast is com-

posed or made up of several *lobes*, formed by rounded granulations of a rosy white colour, about the size of a poppy-seed. "It is supposed, that each of these granulations are [is] composed or formed by the union of a number of small vessels"[?]. "Around the nipple there is a circle of skin or disk." "In the want of ovaria, the breasts will remain, as in an early stage of life, undeveloped; but a false conception is attended with a fulness of the mammæ, so that *their* existence must have considerable influence upon *their* functions." "Any derangement in one or more of the organs necessary to be in health for the due *performance of the menstrual period* [!], will more or less affect the mammary glands, *the severity depending upon the primary cause.*"

Page upon page is here extracted from Liebig's "Organic Chemistry," to give a "short notice of the chemical characters of some of the tissues of the animal economy." In treating of lactation, Mr. Tuson informs us that "sometimes, when the child is brought to the mother, she feels an internal commotion of the breasts, *influenced, no doubt, by the thoracic viscera.*" "The maternal office of suckling is always attended with a calm serenity of mind, *scarcely felt in other situations*: and the suppression of milk, on its first appearance, with irritability, languor, or despondence." "It is stated upon authority, that girls of the best character, by the irritation of a child sucking, have *become able to support it*;"—a consolation certainly for needy young women placed in such circumstances! "The number of teats or nipples in different animals corresponds usually to the number of their young: *they are generally even*: sometimes in women there is an additional nipple" [when they have twins, we presume] "or more, and sometimes these have been *discovered only by accidental causes.*" These extracts will sufficiently exhibit the author as an anatomist, a physiologist, and a writer. In the last respect, nothing assuredly could be worse.

Mr. Tuson next proceeds to classify the diseases of the breast; and the same confusion of intellect and inaccuracy of expression are exhibited here as in the previous sections. We have not space, however, to go into many specifications. Under "undue lactation," we are told that "the intermarriages of cousins have been fully established to produce weak and delicate children by



*the admixture of the blood of one branch*”—an assertion which we do not clearly comprehend. Speaking of milk abscess, he says, “An endeavour ought to be made to disperse these abscesses, *the same* as the treatment of another complaint”! In a case of this kind, Mr. Tuson prescribed the *hydrochloride* [hydrochlorate] of *ammonia*! Eighteen pages from a paper by Cruveilhier constitute the remarks on fibrous tumours; and Sir Benjamin Brodie and Dr. Copland minister largely to the articles on encysted tumours, and on cystic and hydatid tumours of the breast. To the class of organic lesions, comprising tumours or formations of a malignant and contaminating character, Mr. Tuson has devoted most of his attention. His desire manifestly is to be regarded by the public as an experienced “cancer doctor.” It is strange, that the excellent article in the *Cyclopædia of Surgery* by Dr. Walshe, which was re-printed in a separate form in this country, should have wholly escaped his attention, and that he should state Müller to be “the latest and best authority” on the subject. In lieu of Müller, however, we have six pages containing Sir E. Home’s views on the formation of scirrhous tumours from Sir Astley Cooper’s Lectures, and thirty-four consecutive pages from Dr. William Budd. Dr. Copland’s Dictionary furnishes several pages to *Fungus Hæmatodes*.

We pass over Mr. Tuson’s pseudo-scientific twaddle on the mode in which cancer is produced. Here, Turner and Bostock, Marcet, Prout, Liebig, Müller and others are laid under heavy contributions, often without our being able to discover the precise object of the author. We shall notice briefly, however, the armamentarium which he brings to bear on this formidable malady. We may remark, by the way, that he seems occasionally to take from others without the slightest indication of the authority; as, for example, when he says, in speaking of the treatment of cancer—“The section of Van Swieten, *which I mentioned to you to-day* on the subject of cancer, is 499.” Mentioned to whom? This is marvellously like as if it were extracted from some published lecture.

*Chloride of zinc* comes in for favourable mention, and we are told that “*Dr. Conguoin* [Canquoin] in Paris” employed it. “But this remedy,” he says, “like many of the preparations that have been recommended, is only of use in arresting the pro-

gress of this formidable disease. We are flattered by vain anticipations of curing the disorder, buoyed up with hope which is fallacious and disappointing, whilst the cancerous disease continues slowly in its progress, daily gaining an ascendancy upon the constitution, until death alone checks its malignant propensity." p. 401.

The effect produced by the internal administration of one-third or half-a-grain in water, even once a-day, "changed the character of the cancer from a diffused form, which extended over a large surface, to a more circumscribed extent." p. 409. The preparation, he says, affected the gums in the same way as preparations of mercury ; and in one case, the medicine was obliged to be discontinued for this reason.

Solutions of *chloride of calcium* in water, Mr. Tuson affirms, will be found very useful in many foul, ulcerated cancerous affections, especially when the fœtor is excessive. *Chloride of carbon* is, however, most highly recommended by him. He gives it internally in the dose of one drop, at night, in water, and increases the dose to two or three drops. "In many cases it produced perfect freedom from pain, quieted the mind and nervous system generally, prevented the rapid growth and progress of the disease ; and rendered the patient's life *comparatively happy to their previous feeling and condition.*" p. 412. In every form of cancer it proved an excellent anodyne, given internally, as well as applied locally. The usual strength, as a local application, is a drachm of the chloride to a pint of water. Mr. Tuson recommends it mixed with water as a gargle in foul ulcerated sore throats, and in various other affections where disinfectants are needed. The article used by him under the name *chloride of carbon* has been variously termed by modern chemists—*chloroform*, *chloric ether*, *terchloride of carbon*, *chloride of formyle*,\* &c. Mr. Tuson has seen a favourable change take place in cancerous ulcers from the local application of *Heuchera*, alum root ; but it soon ceases to have the same effect. "In some cases when the cancer bleeds, it may be very advantageously applied, as it frequently prevents hemorrhage." p. 424.

\* For its mode of preparation, medical properties, &c., see the Fifth Edition of Dunglison's New Remedies, p. 612. Philadelphia, 1846.



*Perchloride of copper*, formed by dissolving peroxide of copper in muriatic acid, and evaporating to dryness by a heat below  $400^{\circ}$ , has been used by him on many occasions to cancerous ulcerated sores, in the form of a lotion, made of the strength of six grains to an ounce of water. "I consider it likely," he concludes, "to be very beneficial *under certain circumstances.*" p. 426.

Of *chloride of potassium* he speaks as follows:—"I have administered this preparation, internally, in doses of from three to six grains, twice and three times a-day: the patients have been unable to continue it on account of it [its] causing uneasiness and troublesome sensations in the head." p. 426.

Can such be the effect of the chlorohydrate or muriate of potassa? And what effect in cases of secondary eruption could be expected from four grains of this neutral salt dissolved in one ounce of water, which Mr. Tuson says is "one of the best lotions that can be prescribed"!

*Chloride of lead* was employed by him, "both in the form of lotion and ointment with some success."

Other remedies, commonly given in cancer receive a passing notice from Mr. Tuson; but the above are those which he advises; and most of all—as before remarked—the chloride of carbon. We confess, however, that we rise from the perusal of his statements and cases with, we think, well-founded doubts as to the accuracy of his observation, and the purely professional character of his motives. The whole work seems, indeed, as if it were intended to impress the public rather than the profession; and we feel compelled to say, that we have not seen, recently, any production from any source, respectable by position, which has given us a more unfavourable opinion of the professional and literary qualifications of its author. Yet notwithstanding this, we should not be surprised if it should be reprinted in this country; so great is the rage for re-producing every thing that appears abroad.

*Chemistry of the four seasons, Spring, Summer, Autumn, and Winter: An Essay principally concerning natural phenomena admitting of interpretation by Chemical Science, and illustrating passages of Scripture.* By THOMAS GRIFFITHS, Professor of Chemistry in the Medical College of St. Bartholomew's Hospital; Author of "Recreations in Chemistry," and "Chemistry of the Four Elements." 12mo. pp. 451. Lea & Blanchard, Philadelphia, 1846.

This Essay is founded upon Lectures delivered by the Author at Scientific Institutions in London and Liverpool. It was very recently published in London, and is now republished by the well known Philadelphia house above named. It will be perceived from the title page of the work, that it is not designed so much for the professional as the general reader; and yet we venture to express the opinion that no one can read it, not even the professed Chemist, without both pleasure and profit. We have found it, indeed, one of the most interesting *popular* treatises that we have met with for a long time, on any subject—interesting for the facts which it contains, the inferences and reflections arising from the consideration of these facts, the chaste but glowing language in which it is written, and the beauty and aptness of the illustrations employed by the author to enforce and explain his views. We subjoin one or two brief extracts, not for any thing new that they contain, but to afford to the reader some idea of the kind of matter of which the essay is composed, and the manner in which the subjects are treated.

"Dark soils absorb heat more powerfully, and radiate heat more energetically than light colored soils, which reflect a great portion of heat; we have now to examine how these facts, and others concerning the mere alteration of surfaces in affecting both absorption and radiation of heat, are applicable to the explanation of a beautiful phenomenon of Summer and Autumn.

"The night has been serene, the moon and stars have shed their brilliant light, no clouds have obscured the heavens, no rain has fallen, and yet when we step forth at daybreak, we find the grass and flowers of the field loaded with myriads of drops of water, sparkling like gems in the golden rays of the rising sun.

"We recognize this beautiful phenomenon as Dew;—but from whence has it silently journeyed and arrived during the hours of night?—can the chemist reply?



"He can ; and the reply will furnish another example of the power and goodness of God, for 'His favour is as dew upon the grass;' another proof of the ever-watchful care of Him with whom 'the darkness and the light are both alike,' whose hand is equally extended for the protection of the animated creation during its noontide activity and its midnight repose.

"Throughout the fervent glow of a Summer or Autumnal day, the solid opaque earth absorbs heat: this abides upon its mere surface, and is not conducted beneath; but at sunset, if the sky be cloudless and calm, the earth immediately radiates part of the heat upward, and soon becomes many degrees colder than the air directly incumbent upon its surface; accordingly the watery vapor that is present in the yet warm air, is chilled or condensed into drops of water, and these 'distil as the dew' upon the earth, for the refreshment of its productions.

"This phenomenon cannot fail of appearing remarkable, even to the most careless observer, and it becomes yet more so when accurately investigated by the chemist. Examine a garden immediately after sunrise at this season; probably the grass-plot is saturated with dew; the gravel walk is nearly dry; the leaves of the hollyhock are dripping with water; the leaves of the laurel are free from moisture; but all these objects were similarly exposed to the night air, and if dew were a fine rain, as some persons imagine it to be, all should be equally covered with its drops; why is this difference observed?

"Because the surfaces of the various objects differ in their radiating power; the grass-plot and the leaves of the hollyhock are excellent radiators; they throw off heat with great energy, and so becoming cold, they induce a more copious deposition of water from the air than the gravel-walk and the laurel leaves, which, being bad radiators, retain heat and remain so warm that the watery vapor in the air wafts over their surfaces without being chilled or condensed, and therefore they are free from dew.

"Rough or woolly leaves, like the painted or sanded surface of the tin-plate, radiate heat most rapidly, whilst smooth or varnished leaves, like the polished or bright surface of the tin-plate, do not radiate with such energy, and as a consequence of this, the former leaves ensure a more plentiful deposition of dew than the latter.

"From the limits of the garden, let us carry forth these observations and facts into the boundless fields of Nature, and discover the miraculous workings of Providence.

"Barren rocks and soils, by reason of their peculiar hard and compact structure, have neither the power of absorbing nor of radiating heat with great energy; they do not speedily acquire a low temperature during the clear nights of Summer and Autumn.

and as a consequence, dew is scarcely, certainly not abundantly, deposited upon them; it is not required for their support, and they have no vegetable life, or but little of the lowest grade to maintain."

We have given more space to this little work than we are accustomed to bestow on such as are not strictly professional in their character, because it treats of many topics on which physicians, and particularly country physicians, ought to be well informed. If treatises on all the subjects of science, and especially medical science, written in the same familiar style, were generally circulated, it would do more to put down quackery and imposture, by enlightening the minds of the public, than all the conventions and legal enactments in the world.

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*New Remedies.* By ROBLEY DUNGLISON, M. D., Professor of the Institutes of Medicine, etc., in the Jefferson Medical College of Philadelphia. *Fifth edition, with extensive additions.* Svo. pp. 639. Philadelphia, Lea & Blanchard, 1846.

"The enlarged experience of observers," says the author in his preface to this edition, "since the appearance of the fourth edition of this work, has tested the value of many articles contained in it, and given occasion to the incorporation of much new matter with the text. New remedies have also been proposed in no small number; so that the present edition is much larger, and describes many more articles than the last."

A work like this is obviously not suitable for either critical or analytical review. It is, so far as it goes, a dispensatory, in which an account is given of the chemical and physical properties of all the articles recently added to the materia medica and their preparations, with a notice of the diseases for which they are prescribed, the doses, mode of administration, &c. For the accuracy of these statements, those on whose authority they are given are alone responsible, and the names of such are invariably given by the author. Further experience, in some instances, will doubtless correct or limit the over confident opinions of those by whom some of these new remedies are proposed, whilst in other cases, perhaps, remedial virtues will be discovered which they are not now thought to possess. The same remarks are applicable to some of the



articles long used, and now proposed for new objects : time and further observation must determine the degree of confidence to which they are entitled. All that can be expected in a work like the present is, that it shall be full in its contents, accurate in its details, and faithful in its references. That the present publication is of this character, need scarcely be said, when we regard the source from whence it comes. No man living, probably, is better acquainted with whatever is new or valuable in medicine than the author.

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*Special Anatomy and Histology.* By WILLIAM E. HORNER, M. D., Professor of Anatomy in the University of Pennsylvania, Member of the Imperial Medico-Chirurgical Academy of St. Petersburg, of the American Philosophical Society, etc. In two volumes, 8vo. *Seventh edition, with numerous Illustrations.* Lea & Blanchard, Philadelphia, 1846.

The first edition of this work appeared in 1826, previous to which mere *Descriptive Anatomy*, with very little of *General Anatomy* or *Histology*, occupied the pages of works devoted to this subject. A closer investigation of the tissues which make up the various organs and portions of the body, facilitated and in a great degree prompted by improvements in the microscope, has enlarged the boundaries of the science, and added new incentives to the study of this branch of medical knowledge; hence, instead of *one* volume, the work of Professor Horner has expanded into *two*, of portly dimensions.

In a somewhat lengthy *Preface* to the present edition, the author observes :

“ In presenting to the profession a seventh edition of his work on *Special Anatomy and Histology*, the Author remarks, that it is not a mere re-print of the last edition, published three years ago, which itself contained copious additions over its predecessors; but that it has undergone several modifications, and many extensions, derived from the progressive state of the Science of Anatomy.”

This edition likewise contains additional illustrations, derived from the best authorities; “ and it is placed in a more immediate relation with the volume of plates, by Dr. H. H. Smith, called *Anatomical Atlas*; they having been selected expressly as an

elucidation of its text. 'This connection has been done by specific references at the foot of the page to the plates in question.' So says the *Preface*.

When a work which is purely scientific, and without the advantages of a very correct diction, passes to a seventh edition, as in the present instance, it is pretty conclusive evidence of its merits.

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*A Manual of Examinations upon Anatomy and Physiology, Surgery, Practice of Medicine, Chemistry, Obstetrics, Materia Medica, Pharmacy, and Therapeutics; to which is added, a Medical Formulary. Designed for Students of Medicine throughout the United States.* By J. L. LUDLOW, A. M. M. D. *Second edition, revised and enlarged.* 12mo. pp. 689. Ed. Barrington & George D. Haswell. Philadelphia, 1846.

"Our object is," says the author, "simply, to give at a glance the principal points necessary to guide the student in the prosecution of his studies, and to revive his recollection of subjects treated upon in more voluminous works."

"In this edition, many additions have been made to keep up to the Science as it has advanced, and is advancing; and in some instances a new arrangement of subjects has been deemed advisable."

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*A System of Anatomy for the use of Students of Medicine.* By CASPAR WISTAR, M. D., late Professor of Anatomy in the University of Pennsylvania. *With notes and additions,* by WILLIAM E. HORNER, M. D., Professor of Anatomy in the University of Pennsylvania. *Ninth Edition; entirely remodeled, and illustrated by more than one hundred Engravings.* By JOSEPH PANCOAST, M. D., Professor of General, Descriptive and Surgical Anatomy in Jefferson Medical College of Philadelphia, Lecturer on Clinical Surgery, Fellow of the Philadelphia College of Physicians, etc. In two vols. 8vo. Thomas, Cowperthwaite & Co. Philadelphia.

A work which comprises the views and observations of three distinguished teachers of Anatomy, presents more than ordinary claims to the attention of practitioners and students of medicine. The present work, however, has been so long and so extensively



before the profession that its merits are too well known to require that we should do more than mention what changes and additions have been made in the present edition.

The text we perceive has undergone revision, and considerable new matter, relating more particularly to histology, has been introduced. Several wood cuts have also been added, and the beautiful copper plate engravings of the arteries by Sir Charles Bell, properly coloured, are inserted, and add very much to the value of the present over former editions.

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*An Anatomical Description of the Diseases of the Organs of Circulation and Respiration.* By CHARLES EWALD HASSE, M. D., etc. *Translated and Edited* by W. E. SWAINE, M. D., etc. 8vo. pp. 377. Lea & Blanchard, Philadelphia, 1846.

In a former number (August, 1846) we noticed this work of Dr. Hasse in terms of suitable commendation. The fact of its being translated and published under the direction of the Sydenham Society, is alone sufficient evidence of its high character, and our townsmen have conferred a favour on the profession in this country by its re-publication. It is a standard work, and ought to be in the library of every physician.

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## THE MEDICAL EXAMINER.

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PHILADELPHIA, NOVEMBER, 1846.

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### PHILADELPHIA MEDICAL COLLEGES.

The period for the commencement of the courses of instruction in our Medical schools is near at hand, and physicians and students are hourly coming into the city to join the classes; how large these will be, it is yet impossible to tell, but from all the indications before us, we shall not be surprised if the numbers should exceed those of last winter. The season thus far is mild, and the city healthy, and every thing bodes a pleasant and profitable winter for our guests.

*The Annalist ; a Record of Practical Medicine, in the city of New York. Edited by WILLIAM C. ROBERTS, M. D., etc.*

This is a new Medical Journal, of which we have received the first two numbers. It is to be published in New York, on the first and fifteenth of every month, and contain twenty-four pages of matter.

The editor, in his inaugural address, remarks: "On presenting to the profession the first number of a new medical periodical, the editor naturally feels that the untimely end of its many predecessors will be remembered, and that a similar speedy decline will be predicted of this." He adds "his own assurances to those of his publisher," however, "that such arrangements have been made as place its continuance beyond the contingency of failure"—to which we heartily respond *amen*. The editor declares "His aim is to make the *Annalist* an arena in which all may meet on equal terms, to confer upon the great subject which occupies their every thought, and forms the business of their lives. All who adorn the medical name by purity of private and professional character, and pursue steadily the straight, but rough and narrow path of Legitimate Medicine, shall be welcome to the use of its pages; but to no others will they be open."

These sentiments manifest an honest purpose, and must secure for our brother the best wishes of all the true friends of our noble profession.

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NEW YORK MEDICAL SOCIETY AND QUACKERY.

"*Shall the Charter of the New York Medical Society be surrendered?*"

In a late number of the New York Medical and Surgical Reporter, (Oct. 10th, 1846,) this question is discussed with much point and spirit by Dr. Calkins, as a means of getting rid of all connection and fraternization with certain members, who it appears are degrading the profession by their empirical conduct. As a legally constituted body, it cannot expurgate itself by the removal of unworthy members, without the interposition of the judiciary, as we infer from the writer's remarks—the power to exclude not being co-ordinate with that to elect. This necessarily is attended with many difficulties, and legislative action would be required to render the procedure practically useful. The writer appears to think it would not be expedient to deal with Homœopaths and such as pursue a course more or less popular.

"The crude and wayward convictions of the multitude, preposterous as they would appear to the professional eye, must be treated as we would handle the currency, estimating its denominational as well



as its intrinsic value. In a science of all the most recondite, and amidst theories the most discordant and latitudinarian, how in reason can the popular mind be expected of itself to discriminate, and choose the expedient and safe, to the rejection of the doubtful or the hazardous?

"If, indeed, a flagrant breach of morality comes under our cognizance, if a course of practice is pursued palpably clashing with the primary laws of rectitude and honor, is one chargeable with speculation or other fraud, is the reckless vender of damnable nostrums seen fleeing for shelter to the broad seal of our Society, let us bring him up for sentence, and post him as a renegade and an outlaw. Who shall gainsay the right, or be captiously clamorous against its enforcement?"

Homœopathy, of which the writer appears but little enamoured, ought, he thinks, to be put to the test, as in Paris. "We cannot refer to developments made three thousand miles off, but we might institute, as was done in Paris, a mixed commission, with authority and facilities to make a grand comparative experiment and then publish the results. Such is the trial that the homœopathsists themselves profess to covet; the very ordeal, I am bold to aver, they of all things would deprecate and shrink from."

If our brethren in New York should undertake to disprove every ridiculous and pernicious scheme that quacks may devise for fleecing the brainless multitude, they will have little time left for science and their patients. What did the mixed commission in Paris accomplish? It proved to the conviction of every disinterested and right thinking mind that homœopathy, practically carried out, is a humbug; and that was just what physicians and intelligent people thought of it before: but did it stop the mouths of the knaves who profited by it, or convince silly ladies and crotchety old gentlemen—people who are governed by faith, and not by reason—a faith which is truly to them "*the evidence of things not seen*"? Not at all. Such people are never convinced, although they are often converted—but it is to some new folly, frequently greater than the first.

The same Journal from which we have derived the above, tells the following queer story. We think such an *accident* could hardly befall either the *Philadelphia Medical Society*, or a Philadelphia College.

"A WAY TO GET A DIPLOMA.—There is a certain advertising quack in this city, who is said to have obtained a diploma from a Medical College, in the following manner. When he first came to this country he commenced peddling about the streets with a small basket on his arm, which barely enabled him to support his family; but meet-

ing with one of his countrymen, an old German physician, who had been well educated, and had enjoyed a good practice, until he became dissipated, which brought upon him disgrace and degradation, and prepared him for baser deeds and meaner associations; said physician, on coming to this country and becoming acquainted with our hero of the toy-basket, and his peculiar mind, advised him to become a doctor. How can I do that when I have no previous education? asked the pedlar. The German doctor replied, You must feign that you cannot speak English, and I will interpret for you, but we must not let the Professor know that I am a physician. All preliminary arrangements being made, and the story having been given out, that the Dutch pedlar had been a surgeon in Napoleon's army, ect., he was examined, and his friend interpreted to suit the case.

The result was, *that he passed a pretty fair examination considering his having been educated in another country, and being wholly unacquainted with our language and mode of examination.*

The diploma being obtained, served him as a passport into the Medical Society of the city and county of New York.

We next find his flaring advertisements in nearly all of our city papers, telling of his *celebrated elixirs and wonderful cures.*

This is but one of the impostors, who have crept into this once highly honorable society, composed of the medical profession of this city, but now, alas! how changed.

Can it be wondered at, that those gentlemen who feel a just indignation at seeing themselves and the profession so trampled upon, should now take some active measures to rid themselves of such mountebanks, or dissolve the connection by giving up the charter?

At the next meeting of the Society, we shall expect to see some action brought forward on the subject."

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*Annual Announcement of the Medical Department of the University of New York.—Session of 1846-7.*

We have rarely met with a circular from a medical school so little in accordance with our notions of good taste and good feeling as this, nor have we seen one that drew so largely upon the credulity of its readers. Not to go too much into particulars, we shall refer to only two or three examples.

The title page is ornamented with a neat wood-engraving of a very fine building appropriated to the *Academical* department of the University, which, beside being a long way from that in which the Medical Lectures are given, is as unlike it as it is unlike any other building in the city—as unlike it as *a granite fronted building with the lower story filled with shops*, is unlike the handsome marble building figured in this publication.



The language employed throughout this Announcement, it seems to us, is eminently hyperbolic. One object appears to run through all its pages, and in every paragraph—that of impressing the reader with the belief that the Medical Department of the University of New York is *the great school of the country*! Nay, the schools of Europe, as well as those of America, are brought into invidious comparison. In this, however, “the Faculty would not arrogate to themselves superior talents or learning”! What then? “A few years since, and New York was known only as the *Commercial Emporium*; her fame in Medicine had not travelled beyond the confines of her own state; and her Medical classes were insignificant in numbers, composed mostly of students residing in the vicinity of the city.” What then has made the wonderful change so complacently dwelt upon, if not the “superior talents and learning” of the Faculty by whom this Announcement is issued? The city was there—the people, the hospitals, the dispensaries, a well organized medical school—every thing except the “Medical Department of the University of New-York”!

The ridiculous fastian about “*building up a national school worthy of the country and the age*,” is truly laughable. Why should a school in the city of New York be *national* any more than in Philadelphia, Cincinnati, New Orleans, Boston or Baltimore, and why the school in the Stuyvesant Institute in Broadway, any more than that in Crosby street? Such extravagant pretensions, bombast and self-laudation, are little calculated to gain the esteem and secure the confidence of the thinking public, and least of all, the medical public.

The Faculty in this Announcement boast of a “surplus of the *materiel*” for practical anatomy, and at the same time intimate that they have induced the municipal authorities to prevent the appropriation of this “*surplus*” to the use of students of anatomy out of the city of New York. This ungenerous policy has already drawn down upon them the thunder of the press, and it is very unlikely that the New York Medical Colleges *out of that city* will quietly submit to such a course; and if it should bring difficulty, or even deprivation upon themselves, it may be to them a cause of future regret rather than exultation. A liberal and frank policy is always the best in the end.

We perceive by this Announcement that the number of the last Class was 407, instead of 425, as stated in the Buffalo Medical Journal and copied into our last number.

*Annual Announcement of the Medical Department of Pennsylvania College.—Session 1846-7.*

In the list of Medical Colleges published in our last number, the Medical Department of the Pennsylvania College was accidentally omitted. From this publication we learn that during the incumbency of the present Faculty, the Classes have been as follows, showing a rapid increase :

1843-4	Class	23	Graduates	7
1844-5	"	60	"	14
1845-6	"	94	"	36

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PHILADELPHIA COLLEGE OF PHARMACY.

We have been furnished by a friend with a pamphlet containing a *Report* of the Philadelphia College of Pharmacy, with a catalogue of its Members and Graduates.

The *Report* very justly says that "The length of time that has elapsed since the organization of the PHILADELPHIA COLLEGE OF PHARMACY, and its steadily increasing reputation and usefulness, have placed it among the established institutions in our country for the promotion of science." It is one of those institutions which have accomplished great good, without the least admixture of evil.

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PRIVATE MEDICAL INSTITUTE.

We have received a *Circular* of a private Medical Institute, in Baltimore, conducted by our old friend Dr. J. R. W. Dunbar. We notice in this circular very ample means for the advancement of students, such as books, models, skeletons, preparations, &c., and are pleased to discover that a large number of gentlemen avail themselves of them. Dr. Dunbar is well qualified by temper and acquirements for the task he has assumed.



## RECORD OF MEDICAL SCIENCE.

*Lectures on some of the more Important Points in Surgery.* Delivered at the Royal Westminster Ophthalmic Hospital, Charing Cross. By G. J. GUTHRIE, F. R. S., &c.

## LECTURE VIII.

*General Conclusions.*

1. The Hunterian operation for the cure of an aneurism is not applicable to the treatment of a wounded artery, inasmuch as the wound of the artery communicates with the external parts, and nothing intervenes to prevent blood flowing from the wound in its side, or from its cut extremities.

2. When a large artery is divided and bleeds, the wound should be enlarged if necessary, and a ligature placed on both the divided ends; but if the artery be only injured and not quite divided, the ligatures should be applied one immediately above, the other below the injured part. The artery may or may not be then cut across, at the pleasure of the operator, but the limb or part should be placed in a relaxed position. A bandage should not be applied, and the edges of the wound should be simply brought together by adhesive plasters, which do not extend completely round the limb.

3. No operation is to be performed on any artery unless it bleeds at the moment of its performance, inasmuch as hemorrhage once suppressed may never return.

4. The intervention of muscular fibres, or of whole muscles, is not a sufficient reason for tying the artery at a distant part. They must be divided, if it be possible, to the extent required for a due exposure of the injured artery and its accompanying veins and nerves.

5. If the wound pass indirectly to the principal artery, from the back of the thigh for instance to the femoral artery in front, or from the outside of the arm to the humeral artery on the inside, the surgeon may (on satisfying himself of the part likely to be injured, by the introduction of a probe) cut down on a vessel opposite that supposed to be wounded, by the most simple and approved method. When the artery is exposed, the probe will point out the spot at which the vessel has in all probability been wounded. Pressure made below this spot on the artery, will cause it to be distended and to bleed, if the flow of blood be not prevented from above; the artery is then to be secured by two ligatures, and the lower one should if possible be applied first.

6. The tourniquet should never be applied in an operation for aneurism or for a wounded artery. Compression by the hand in the course of the wounded vessel is allowable.

7. The blood from the upper end of a divided artery, or that nearer the heart, is of a scarlet arterial colour.

10. The blood from the lower end of a divided artery, or that which is further from the heart, is of a dark or venous colour, when it happens to flow immediately after the division of the vessel. At a subsequent period it may assume more of the colour of arterial blood, but it rarely does so for several days after the receipt of the injury, and always flows, or at least until a very late period, in a continued stream.

11. This regurgitation or flow of blood from the lower end of a divided artery is a favorable sign, inasmuch as it shows that the collateral circulation will probably be sufficient to maintain the life of the extremity.

12. The collateral circulation is in almost every instance capable of maintaining the life of the upper extremity when the axillary artery is divided, and the colour of the blood which flows from the end of the artery, on its being divided, is not always as dark as in the lower extremity, and it sooner resumes its arterial colour.

13. The collateral circulation is not always capable of maintaining the life of the limb when the femoral artery is injured. The best assistance which art can give is to rub the foot and leg in the gentlest manner, between the hands of one or two strong young women, for several hours, or even for the first three or four days; relaxing this process very little, even during sleep. When the vein is divided at the same time, or rendered impervious, the limb usually mortifies.

14. The collateral circulation is sufficient to maintain the life of an extremity in almost every case in which an aneurism has existed for eight or ten weeks, although it may be incapable of doing this if the principal artery has been suddenly divided, without any previous disease having existed in the part.

15. The theory and the operation for aneurism are never to be applied to the treatment of a wounded artery, which has caused a diffused or circumscribed aneurism, *whilst the external wound communicates with the artery*, unless it be impossible or impracticable to tie the bleeding vessel.

16. When an artery has been wounded, and the external opening has healed for weeks or months, so as to give rise to a diffused or circumscribed aneurism, it may be treated according to the theory of aneurism occurring from an internal cause, if the case will permit it without danger, although with this difference, that as the artery is sound the operation may be performed close to the tumour. If any doubt exist as to the capability of the collateral circulation to support the life of the lower extremity, when the external iliac is secured by ligature, the operation should be performed at the injured part by opening the swelling and enlarging the wound, as in the case of a wounded artery.

17. When a circumscribed or diffused aneurism has formed after a wound has been opened, whether by accident or design, it is placed in the situation of a wounded artery, and should be treated as such. If the aneurism has arisen from disease of the vessel, and the wound or opening into it cannot be permanently closed, the limb is



in a worse state than if the artery had been wounded by accident; because a ligature or ligatures placed on a diseased artery are little likely to be successful. They are liable to all the difficulties and inconveniences attendant on the old operation for aneurism. If a case of the kind should occur in a popliteal or femoral aneurism, situated at or below where the artery passes between the triceps and the bone, amputation, if it can be done low down, will be the best remedy. If the aneurism should have formed higher up, and the opening can be closed with any prospect of its healing, a ligature may be placed upon the artery above it; but on the recurrence of hemorrhage which cannot be restrained by moderate pressure, the artery must be tied below, or recourse had to amputation. It is, however, to be observed, that amputation under these circumstances, when resorted to as a third operation, rarely succeeds.

18. When an artery is wounded with a simple fracture of a bone, or with a comminuted fracture of smaller bones, with an external communicating opening, both ends of the artery should be secured, and the limb treated in the usual manner.

19. When the bone broken is the femur, and the artery divided is the femoral artery, the operation of amputation will generally be advisable. It will always be so if the fracture is a comminuted one, or the shaft of the bone is extensively split.

20. When the broken bone injures the artery and gives rise to an aneurism, the treatment is to be first of the fracture and then of the aneurism, as soon as circumstances render it advisable or necessary to have recourse to the operation for aneurism, and which can only be after time has been given for the collateral branches to enlarge, so as to maintain the life of the limb.

21. When mortification takes place in addition to, or as a consequence of a wounded artery, amputation should be had recourse to forthwith.

22. The place of operation should be in almost all cases at the seat of the original wound; but there may be an exception, viz:

23. When the injury has been a mere cut, just sufficient to divide the artery and vein immediately below Poupart's ligament, and mortification of the foot supervenes, amputation should be performed below the knee, or at the part where the mortification more usually stops for a time.

This rule is founded on the observation, that great efforts are made by nature to arrest mortification a little below the knee. Sometimes they succeed; when they fail, death is almost inevitable. The advice to amputate at this part is founded on the fact of its being infinitely less dangerous, when done there, than on the thigh, independently of saving a joint.

24. When mortification has *continued for several days*, and is spreading without having once stopped, the constitution of the patient being implicated as marked by fever, amputation should not be performed until the mortification has been arrested and the line of separation has been well formed. In many cases, where there is great

weakness or of irritability of constitution, it will be advisable to defer the operation to a later period, particularly if there be hope of the patient's becoming stronger and more tranquil.

25. If the mortification has once stopped and then begins again to spread, it will never again cease to extend, and amputation may give some chance of life.

26. Amputation of the arm should never be had recourse to, in consequence of a wound of the axillary artery, unless mortification takes place.

27. When mortification takes place after the operation for aneurism, the surgeon must be guided by the state of the patient's constitution, in resorting to or refraining from amputation.

28. When hemorrhage takes place from the surface of a stump, the artery should be tied at the part from which the blood comes in the first instance, if it can be easily done. If this should not suffice, the artery must be tied higher up, just at such distance as will afford a fair hope of its not having been affected by the derangement of the stump, which has led to the failure of consolidation in the extremity of the artery, and yet not too high to admit of the junction of any large collateral branches. If the bleeding proceeds from several small vessels, and cannot be arrested, the principal trunk should be tied above the diseased part, and the patient removed to a pure atmosphere, without which the operation rarely succeeds in any case.

29. When an aneurismal tumor mortifies, it is unnecessary and improper to tie the artery above the tumor, because it will be obliterated if the mortification be arrested by the efforts of nature, which the operation may interfere with, and even prevent, whilst, if the mortification spreads, it will be a matter of supererogation, and only hasten the patient's dissolution. When an aneurism inflames, is opened by ulceration, and bleeds profusely, it is a proper case for amputation, if such an operation can be performed.

*On the Operations of placing a Ligature on the Aorta, on the Common Trunk of the Iliac, and on the Internal and External Iliac Arteries.*

In performing either of the three operations, it is advisable to compute the point at which the artery is to be tied, with relation to the umbilicus and the anterior superior spinous process and the crest of the ilium. The aorta bifurcates usually on the body of the fourth, or on the intervertebral substance, between it and the fifth vertebra, although it may be higher or lower, which cannot be ascertained previously to the operation; the most usual place being nearly opposite to the margin of the umbilicus on the left side. It is about half an inch above this that the ligature should be placed on the aorta, if this operation is ever done again, rather lower than higher, on account of the origin of the inferior mesenteric artery. As this artery is to be reached by carrying the finger along the common iliac, the comparative situation of that vessel is next to be estimated.

The aorta divides into the two common iliac arteries, the length



of which varies according to the stature of the patient, and the place at which the aorta bifurcates. The common iliacs again divide into the external and internal iliacs, which division is usually opposite to the sacro-iliac symphysis. The length of the common iliac artery is therefore tolerably well defined, as scarcely ever exceeding two inches and three quarters, and seldom being shorter than two inches. The external iliac is a little longer than the common iliac, and the place of subdivision of the common iliac into external and internal can always be ascertained during an operation, by tracing the external iliac upwards to its junction with the internal iliac to form the common trunk, which proceeds upwards and inwards to the aorta. The left margin of the umbilicus being taken as a point opposite to that which may be presumed to be the part at which the aorta divides, and the situation of the external iliac becoming femoral being clearly ascertained, a line drawn between the two will nearly indicate the course of these vessels: sufficiently so, at all events, to enable the operator to mark with his eye the place where he expects to tie the artery, and to regulate the length of the incision, so that this ideal spot may correspond to its centre. It is necessary to recollect also, that the whole of one hand and part of the other must be introduced into the wound, to enable the operator to pass the ligature round the artery, and to tie the knots; so that an external incision of less extent than five inches will not suffice, and six will afford a facility in operating, which will save pain to the patient, and inconvenience to the operator. In calculating the length of the incision, allowance must be made for the size, obesity, and muscularity of the patient. If a rule be placed on the crest of each ilium, about one inch and a half behind the anterior superior spinous process, it will pass in a well-formed man across the junction of the fifth lumbar vertebra with the upper part of the sacrum, and a little way behind where the common iliac divides into external and internal. The centre of an incision, six inches in length, beginning about half an inch above Poupart's ligament, and about the same distance to the outside of the inner ring, and carried upwards, will fall nearly on a line with this point. The incision should be nearly parallel to the course of the epigastric artery, but a little more to the outside, in order to avoid it and the spermatic chord, and having a gradual inclination inwards towards the external edge of the rectus muscle, the patient being on his back, with the head and shoulders raised, and the legs bent on the trunk. The aponeurosis of the external oblique muscle having been opened inferiorly, is to be slit up for the whole length of the external incision; and the director having been first passed under the internal oblique muscle, through a small opening carefully made into it, it is to be divided in a similar manner. The transversalis is then to be cut through at the under part, and its tendinous expansion divided at the upper part, the greatest precaution being taken by the finger to prevent the peritoneum from being injured. The fascia transversalis is then to be torn through at the lower and outer part, so that the fingers may be passed outwards towards the ilium, and the perit

neum detached from the iliac fossa, and turned with its contents inwards, by a gradual and sidelong movement of the fore and second finger inwards and upwards, until passing over the psoas muscle the external iliac artery is discovered by its pulsation. It is then to be traced upwards and inwards towards the spine, when the origin of it and the internal iliac from the common trunk will be felt. The point of the forefinger will then be nearly in the centre of a line drawn from the umbilicus to the anterior superior spine of the ilium; and hence the necessity for an incision of six inches in length, if the artery is to be tied high up, which is to be accomplished by tracing it in a similar manner to its origin from the aorta.

If the *internal iliac* is to be tied, the operator traces it downwards from its origin, in preference to passing his finger from the external iliac artery inwards in search of it. Having placed the point of his fore finger on the vessel at the part where he intends to pass his ligature, he scratches with the nail upon and on each side of it, so as to separate it from its cellular attachments, and from the vein which accompanies but lies behind it. Thus far the operator proceeds by feeling; but it is now necessary that the sides of the wound should be separated, and kept apart by blunt spatulæ curved at the ends, so as to take up as little space as possible, and not injure the peritoneum. The surgeon should, if possible, see the artery, and the ligature carried on the eye of a bent probe, or a convenient aneurismal needle should be passed under it from within outwards, when it should be taken hold of with the forceps; the probe or needle should then be withdrawn, and the ligature firmly tied twice, or with a double knot. Great care must be taken to avoid every thing but the artery. The peritoneum which covers it, and the ureter which crosses it, must be particularly kept in mind. The situation of the external iliac artery and vein, which have been crossed to reach it, must be always recollected, and if there be sufficient space they should be kept out of the way, and guarded by the finger of an assistant.

The *common trunk* of the iliac arteries and the aorta itself may be tied by the same method of proceeding; the only difference which can be practised with advantage will be to make the incision a little longer at its upper part; no inconvenience arising from the addition to the length of the external wound, whilst the subsequent steps of the operation are much facilitated by it. The following method of proceeding, adopted in cases 31 and 108, will bring the method of operating so graphically before the reader that it cannot be misunderstood, and may be readily followed in operating. I began the operation, the patient lying on the back, by an incision on the fore part of the abdomen, commencing an inch and a half below the inside of the anterior spine of the ilium, and the same distance within it, carrying it upwards, and diagonally inwards towards the edge of the rectus muscle above the umbilicus, so that the incision was between six and seven inches long. If the incision is made more outwardly, towards the side in a straight or vertical line from the ilium towards the ribs, great difficulty will be experienced in turning over



the peritoneum with its contents; so as to place the finger on the last lumbar vertebra, an inconvenience which will be avoided by making the incision diagonally and of the length directed.

After dividing the common integuments, the three layers of muscles were cut through in the most careful manner; the division of the transversalis muscle was attended with some difficulty, inasmuch as there was little fascia transversalis, and the peritoneum was remarkably thin—as thin as white silver paper. On attempting to reach the under part on the inside of the ilium, so as to turn the peritoneum over, which in sound parts is always done without the least difficulty, I found that it could not be done on account of the tumor which projected inwards adhering to it, and some bleeding took place from the large veins which surrounded it, giving rise to the caution not to proceed further in that direction. At this moment, in spite of the greatest possible care that could be taken by Mr. Keate, who raised and protected the peritoneum, a very small nick was made in it, sufficient to show the intestine through it. Perceiving that I could not tie the internal iliac as I had at first intended, and that I must place the ligature on the common iliac, I tried to gain a greater extent of space upwards; but where the tendon of the transversalis muscle passes directly across from the lower ribs to and forming the sheath of the rectus, the peritoneum is usually so thin and so closely attached to it that it can be separated with great difficulty. I knew this from the operation I performed in case No. 50, when, in spite of all the precaution I could then take, the peritoneum was at this spot slightly opened. It occurred in the present instance, and the right lobe of the liver was thus exposed.

The opening thus made on the fore part of the abdomen was not large enough to admit two hands. The peritoneum being however separated a little from the posterior wall of the abdomen from the outside, four fingers of one hand were introduced beneath it, and it was turned a little over towards the opposite side. In doing this it must be remembered that the peritoneum must be raised, the hand being pushed towards the back as little as possible, in order to avoid getting behind the fat commonly found in that part of the body, which would lead to the under edge of the psoas muscle instead of the upper surface, and thus render the operation embarrassing.

The peritoneum being carefully drawn over with its contents, I found I could only get one hand, or a little more, underneath it in search of the artery, the tumors below preventing any further detachment of the peritoneum in that direction. I therefore passed my finger across the psoas muscle, and it rested on the fifth lumbar vertebra. The common iliac artery was not, however, to be felt even as high up as the fourth lumbar vertebræ, nor the aorta; they had both risen with the peritoneum, and my finger resting on the spine was beneath them. Mr. Keate endeavoured to raise or draw over the peritoneum, to give me an opportunity of seeing the vessels, but this was out of the question. In doing this, he felt the pulsation of the iliac artery, which had been raised with the peritoneum, to which I

found it adhering. Carefully separating it with the end of the fore finger of the right hand, I passed a single thread of strong dentists' silk, as it is termed, in a common solid aneurismal needle, by the aid of the thumb and fore finger of the left hand, round the artery without seeing it. I could bring the artery a little forward by means of the aneurismal needle, when it appeared to be perfectly clear, and from the distance of the bifurcation of the aorta above, I calculated that the common iliac was tied exactly at its middle part. All pulsation below immediately ceased.

The two ends of the ligature were twisted, the peritoneum replaced in its proper situation, care being taken that the two small openings into it should be well covered under the skin, so that they might not be in the line of the incision, and that they should be covered by partly divided healthy parts, which might thus adhere to each other. Three strong sutures and three or four smaller ones were put in first through the skin, in order to prevent the parts bursting asunder from the movements of the patient. This operation was only formidable from the circumstance, that space could not be obtained for the introduction of both hands, for, strange as it may appear, the safety of, and ease in doing, the operation depends on the first incision in the fore part of the abdomen being so large that the peritoneum containing the bowels may be freely drawn over by the expanded hands of the assistant, so that the operator can see what he is doing beneath. In case No. 107, the whole of the parts under the peritoneum could be seen distinctly, and several gentlemen not in the profession who were present, saw the common iliac artery in its natural situation. The aorta may be as readily tied by this mode of proceeding as the common iliac, and I am satisfied it is in this way such an operation ought to be performed, provided it becomes necessary to attempt it, which I suspect it will not be, for when an aneurism has been formed so high up that it prevents the application of a ligature on the side on which the disease is situated, the common iliac will be more readily tied above it, instead of the aorta, by performing the operation on the opposite or sound side of the body, for as a ligature can be applied with great ease on the sound side on the middle of the common iliac artery, it requires very little more knowledge and dexterity to pass over to the opposite or diseased side, and tie the artery above the aneurismal tumor, the size of which would have prevented the operation being done on its inner or affected side. The placing a ligature on the aorta for an aneurism in the pelvis will thus be rendered unnecessary; this is the most important result to be deduced from the operation described.

The patient suffered little or nothing from the operation, which was performed on Saturday; there was no augmentation of the pulse until Sunday evening, when it rose to 120; she then experienced some pain, which was materially diminished, although not altogether removed, by the abstraction of fourteen ounces of blood. At four o'clock in the morning, Mr. Hancock, now surgeon to the Charing-cross Hospital, took away fourteen ounces more, after which she



had not a bad symptom. The bowels were not moved for the first four days. The temperature of the limb diminished, but not much, which may be attributed to a method adopted in case No. 108. For the first time two persons constantly rubbed the limb night and day, and a hot brick, in baths of hot water, covered by flannel, were applied to the feet, of the temperature of from  $120^{\circ}$  to  $140^{\circ}$ . One nurse rubbed the lower part of the limb, another the upper for three days and nights; if an interval of a few minutes elapsed a hot flannel was put on the limb. The friction was very slight so as not to injure the cuticle. The patient occasionally dozed a little, but the same gentle friction was kept up. The ligature came away on the twenty-sixth day after the operation. The external incision healed very readily, but was followed by a herniary projection, requiring the support of an abdominal bandage.

The situation of the ureter and rectum on the left side of this operation, and of the ureter and the cæcum with its appendix on the right side, should be well understood, and it should be known that the ureter rises with the peritoneum. The relative situation of the common iliac artery and vein should be particularly attended to in passing the ligature around the vessel. On the left side the artery lies external and anterior to its commencement: on the right, the artery passes over the commencement of the vena cava and the left iliac vein, which do not follow the peritoneum when drawn towards the opposite side. The bowels should be thoroughly well evacuated before the operation is performed, but purgatives should not be given for some days after it has been done. The food should be liquid, and inflammation should be subdued by leeches, general bleeding, fomentations, and opium.

The *external iliac* artery has been so often and so successfully tied that a description of the two methods of proceeding commonly adopted will suffice. The first, recommended by Mr. Abernethy, is in accordance with the operations on the common and on the internal iliac. The patient being laid on his back, with the shoulders slightly raised, and the legs bent on the trunk, an incision is to be made about three inches and a half in length in the direction of the artery, and terminating over or a little above Poupart's ligament. The aponeurosis of the external oblique muscle will be exposed, and an opening being made into it, a director is to be introduced, and it is to be slit up to the extent of the external incision. The internal oblique and transversalis muscles, are then to be "nicked," so as to allow a director or the point of the finger to be introduced below them, when they also are to be divided, the finger separating them from the fascia transversalis and peritoneum. The fascia transversalis running from Poupart's ligament to the peritoneum is now to be torn through with the nail, immediately over the pulsating artery, and the peritoneum is to be separated by the finger and pushed upwards until sufficient room is obtained; which, in this as well as in all other operations on the iliac arteries, is sometimes difficult on account of the protrusion of the intestines covered by the peritoneum, when the

patient is not sufficiently tranquil. The artery is yet at some depth, and covered by a dense cellular membrane, connecting it to the vein on its inside, and which must be torn through with the nail. The anterior crural nerve is separated from the artery by the psoas muscle, at the outer edge of which it lies. The aneurismal needle should be passed between the vein and the artery, and the point made to appear on the outside of the artery.

In this operation the ligature is placed on the external iliac, above where it gives off the epigastric and circumflexa ilii arteries; and as the operation is very much the same as that already described, with the exception of the incision being shorter and nearer to Poupart's ligament, it is obvious if it were found necessary from disease to tie the artery higher up, or even to tie the common iliac, that it might be done by merely enlarging the wound.

Another method has been recommended by Sir Astley Cooper, which is perhaps more followed where there is little doubt of the artery being sound. It offers the advantage of greater space, which enables the surgeon to see better what he is doing; but it does not so readily admit of the artery being tied up, without the incision being extended upwards, so as to give more room for the introduction of the hand behind the peritoneum.

"The patient being placed in the recumbent posture, on a table of convenient height, the incision is to be begun within an inch of the anterior superior spinous process of the ilium, and it is to be extended downwards in a semicircular direction to the upper edge of Poupart's ligament. This incision exposes the tendon of the external oblique muscle: in the same direction the above tendon is to be cut through, and the lower edges of the internal oblique and transversalis abdominis muscles are exposed; and the centre of these muscles is then to be raised from Poupart's ligament; the opening by which the spermatic cord quits the abdomen is thus exposed, and the finger passed through this space is directly applied upon the iliac artery, above the origin of the epigastric and circumflexa ilii arteries. The iliac artery is placed upon the outer side of the vein; and the next step in the operation consists in gently separating the vein from the artery by the extremity of a director, or by the end of the finger. The solid curved aneurismal needle is then passed under the artery, and between it and the vein from without inwards, carrying a ligature, which being brought out at the wound, the needle is withdrawn, and the ligature is then tied around the artery, as in the operation for popliteal aneurism. One end of the ligature being cut away, the other is suspended from the wound, the edges of which are brought together by adhesive plaster, and the wound is treated as any other containing a ligature."

This method of operating will suffice when the artery is to be tied for an aneurism which does not extend as high as Poupart's ligament. When it does, the operator will be so much inconvenienced by it, whilst the sound part of the artery above the tumour will be so much



in a hollow behind it in the pelvis, that a ligature will not readily be passed around it, and the disturbance to the peritoneum will be much greater, and much more likely to give rise to peritonitis, than if the incision were made an inch longer on the face of the abdomen. The surgeon, instead of searching for the artery, as Sir Astley Cooper has directed, through the passage by which the spermatic cord quits the abdomen, and thus passing the fingers directly under the peritoneum, will find it very much for his own ease, and for the advantage of his patient, to pass his fingers under the peritoneum from the inside of the wall of the ilium, from which it readily separates, and thus approach the artery from the outside, instead of from below. He will gain more room, reach the artery easily above the origin of the circumflexa ilii, and avoid that disturbance of the peritoneum, in applying the ligature, which often leads to inflammation.

If the surgeon has unluckily divided the epigastric artery, either in this or any other operation, all that he has to do is to enlarge the incision, and tie both the divided ends; and I have no hesitation in saying, it will not be of any consequence, either in this operation or in one for hernia.

*Of the Operation of placing a Ligature on the Gluteal and Sciatic Arteries.*

In all cases of aneurism of the gluteal and sciatic arteries, the internal iliac artery should be tied, instead of an operation on the part itself. In all cases of wounds of arteries which are the only ones rendering an operation for placing a ligature on these vessels necessary, the wound should in a great measure regulate the course of the incision. The operation is an act of simple dissection, first, through the common integuments for the space of four inches, then through and between the fibres of the glutæus muscle to the same extent; a dense aponeurosis covering the vessels is to be next divided, when the bleeding will lead to the injured vessel. In the dissecting-room the operation is described as follows:—Place the body on the face, turn the toes inwards; commence the incision one inch below the posterior spinous process, and one inch from the sacrum, carry it on towards the great trochanter in an oblique direction to the extent of four inches, divide the gluteus muscle and the aponeurosis beneath it, and seek for the artery as it escapes through the upper and anterior part of the sciatic notch, and lying close to the bone. If the vessels of the gluteus muscle bleed, so as to be troublesome, and cannot be stopped by compression, they must be secured.

If the sciatic artery be the vessel injured, the incision should be made in the same direction, but about an inch and a half lower down; if the course of the wound renders it doubtful which artery is wounded, the incision should be as nearly as possible between the two lines directed, the wound being always the best guide; and care should be taken in every instance to include nothing in the ligature but the artery.

*On the Operations on the Femoral Artery.*

Compression should never be made on an artery on which a ligature is about to be placed; because the pulsation is thereby suppressed, and the most important guide to the vessel is at the same time taken away. Where the artery is wounded and bleeding, compression must be had recourse to in the first instance to arrest it; and the first incision must be made without the information which the pulsation gives as to the precise situation of the artery, although the finger may be allowed to rest on the part, underneath which the artery could be felt before the pressure was applied. The external incision should always be made longer or shorter in proportion to the depth at which the artery is situated. It should be at least one-third longer in the middle than at the upper part of the thigh; and whilst a long incision always facilitates the subsequent steps of the operation, it never does harm, unless it be out of all reasonable proportion. The centre of the incision should be if possible directly over that part of the artery on which it is intended to apply the ligature; but no inconvenience will arise from its being applied nearer its upper extremity. The patient being laid on his back, and properly supported, the knee is to be bent and turned outwards, by which the head of the femur will be rolled in the acetabulum, and the femoral artery will be more distinctly felt at the upper part lying on the psoas muscle, having the vein to the inside of it, and the anterior crural nerve about half an inch on its outside, passing between the psoas and iliacus muscles, although some branches soon approach the artery, and run down on the external part of the sheath. The relative position of the parts being duly considered, an incision is to be made directly in a line over the pulsating artery, and carried through the skin, cellular tissue, and superficial fascia, down to the deep-seated, or fascia lata of the thigh. If an absorbent gland should be in the way, it must be turned aside or removed. The *arteria profunda femoris* is given off about two inches below Poupart's ligament, on the back part and outside, whilst three or four small vessels spring from half an inch to an inch below it on the forepart, and one or other of these may be divided. They are the superficial epigastric, the superficial pudic, the superficial circumflex of the ilium, and probably an artery supplying the absorbent glands. If they bleed so as to be troublesome they must be secured, more particularly if the femoral artery is to be tied below them. The fascia lata is now to be divided, with that part of the fascia transversalis, which descending beneath Poupart's ligament forms the sheath of the artery, when the vessel will be exposed. In dividing this fascia and sheath, the point of the knife is always to be directed to the centre of the artery, so that if it be cut by accident it may be seen, when the only result will be the necessity for the application of a ligature above, and one below it. The artery being fully exposed, as ascertained by the pulsation being felt by the finger, it is to be separated from its cellular attachment to the sheath on each side by a blunt or silver knife; and the aneurismal needle or probe,



armed with a strong single thread of dentists' silk, is to be passed under it from the inner or pubic side outwards, by which all injury to the vein from the round point of the needle or probe will be avoided. Two common knots are to be made in the usual manner, when one thread may be cut off, or the two twisted together and brought carefully out of the wound; the edges of which are then to be duly approximated and retained in that situation by sticking plaster and a moderate compress, also secured in a similar manner. The knee is to be bent forward to relax the parts, and laid on the outside with a pillow underneath it.

The needle will pass more easily under the artery if the thigh is bent on the trunk; and before the knots are tied, the surgeon should ascertain that pressure on the part or artery which he has nearly surrounded by the ligature, suppresses the pulsation in the tumour below.

The operation for popliteal aneurism lower down in the thigh is to be done in the following manner:—

The surgeon having turned the knee outwards, and bent the leg inwards into the tailor's sitting position, to show the course of the sartorius muscle, should trace the artery from the groin downwards, until it appears to pass under that muscle. The external incision, four inches in length, made in the course of the artery, should pass over this point one inch, so that when the fascia lata is divided, the sartorius muscle may be seen crossing over to the inside at the lower extremity of the wound. The fascia lata is to be divided for the space of two inches of the incision upwards. The fore-finger is then to be introduced into the wound, and pressure made with it rather outwardly, when it will readily distinguish the pulsation of the artery, still included in its sheath. This is to be opened by slight and repeated touches of the knife directly over the centre of the line of the vessel, or it may be divided on the director, when the artery will be exposed. The point of the fore-finger will easily recognise it from the roundness and firmness of the feeling communicated by it as well as by its pulsation, and the end of the nail, or handle of the scalpel or blunt knife, will separate it with facility from its attachments, to such an extent as will admit the blunt point of the solid unyielding aneurism needle to be passed beneath it from the pubic side. If the point of the needle does not readily come through the cellular attachments of the artery on the outside, this part must be touched lightly with the scalpel, or rubbed with the nail until the ligature is exposed, which should then be taken hold of with the forceps, and one end drawn out, whilst the instrument with the other end is withdrawn. The operator, taking both ends of the ligature, which has been in this manner passed under the artery, between the fingers of one hand, presses upon the artery with the fore-finger of the other, so as to arrest the course of the blood in it, when if there be an aneurism below, the pulsation in it will cease. The ligature is then to be pressed upwards as far as the artery has been detached, and is to be tied with a double knot. The wound is to be dressed as in the pre-

vious case by adhesive plaster and compress, but without a bandage; and the patient is to be placed in bed, with his knee bent forward, or resting on the outside if more agreeable to him,

The operation is done in this manner on that part of the femoral artery which is not covered by muscle, and all interference with the sartorius is avoided. It is the improvement on the Hunterian operation recommended by Scarpa, and ought always to be adopted. This method obviates all discussion as to placing the ligature on the outside of the sartorius muscle; or as to the fear of injuring the absorbents; and as to the saphena vein, it can always be seen, and its course traced up the thigh and avoided. After the first incision is made and completed down to the fascia lata, that part is to be divided, I have said for the length of two inches, but this must be dependent on circumstances; the object being to obtain a view of the sheath containing the artery, the opening into which after the first touch of the knife may be completed with the assistance of the director underneath it; and the artery will be less disturbed in its lateral attachments by an opening into the sheath of three quarters of an inch in length, than by one of half the extent, as it will admit of the aneurism needle being passed under it with more facility, and consequently with less disturbance to the surrounding parts. I have never had reason to believe that a free opening into the fascia of the thigh has done mischief, or even into the sheath, provided the artery has not been unnecessarily disturbed.

The warmth of the limb operated upon should be maintained by gentle friction from the toes upwards to the knee, and when left at rest it should be enveloped in flannel. The wound should not be dressed until the fourth day, the limb being kept quite quiet; the patient should move as little as possible in bed, and the part of the heel on which it rests should be examined from time to time, as it may under pressure become gangrenous.

Suppression of the secretion of urine is not uncommon during the first twenty-four hours, and will be gradually removed by the patient's taking mild diluent drinks. The constitutional irritation in all these operations is frequently great, the pulse rising in forty-eight hours from eighty-five to one hundred and twenty; and if this continue until the third day, when the fear of mortification will have subsided, it should be moderated by the abstraction of a small quantity of blood. In cases of this kind I have had occasion to bleed twice, and with the happiest effect, the pulse having fallen in consequence to its natural standard. The medicines given at the same time were saline draughts every six hours, with four drops of Battley's solution of opium. The ligatures came away on and about the fifteenth day.

*London Medical Times.*

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*Case of Erysipelas, Rheumatism, Jaundice, and Abortion, followed by Puerperal Fever and Death.* By J. CRAWFORD, lecturer on Clinical Medicine and Surgery, M'Gill College, &c.—Mary French,



ætatis 19, a Canadian, unmarried, of spare figure, dark sallow complexion, and bilious temperament, was admitted into the Montreal General Hospital, (18th October, 1845) for an extensive erysipelalous eruption over the right arm, elbow and forearm, which she has had for six days. About two or three days previous to the appearance of the erysipelas, her right elbow and right knee were effected by rheumatic pains, which subsided on the appearance of the exanthem; and she has not had any pain since, unless what may be attributed to the erysipelas; she has also been affected by jaundice for about the same length of time. She had not any thing done for her complaints previously to her admission; at which time her right arm and forearm were considerably swelled, and covered by a bright erysipelalous eruption. The adnata of her eyes was very yellow, and her skin generally tinged of the same hue; her urine was also deeply coloured. The limb was stiff and painful, but nothing to compare with the pain she had suffered at first. She had also smart febrile symptoms, her pulse 108, full, tongue foul, with nausea, hot dry skin, and thirst. She was ordered a purgative of jalap and calomel, and her arm was directed to be brushed over with the tincture of iodine. 20th. The limb is much less swollen, and the redness is paler, and has not extended any farther; there is, however, a great deal of anxiety of countenance, and indication of bodily suffering; her bowels are freely open by the purgative, and she has been taking calomel and Dover's powder four times a day; she is also ordered the infusion of senna to keep up an action in her bowels. 25th. The erysipelas has gradually been subsiding since last report, and is now much better. A small tumour has made its appearance a few days ago, on the inner side of the right elbow, which feels as if there were a collection of matter formed; it is, however decreasing, and appears as if it would be dispersed by the tincture of iodine, which has daily been applied to it. There is still considerable febrile disturbance, with flushing and anxiety of countenance, and profuse acid perspiration, particularly at night: and she complains since last night of rheumatic pain of her right knee, and of her left wrist, which are both slightly swelled; there is no abnormal sound from the heart. The icteric colour of the adnata and skin generally, is still very marked; she slept but little last night, from the pains; her bowels are free. She continues the calomel and Dover powder, and the application of the tincture of iodine, and in addition is ordered an anodyne draught at night. 28th. The erysipelas nearly gone; the right elbow is affected by severe rheumatic pain, and is very powerless. The left wrist is much easier; there is a small soft tumour at the carpal extremity of the left radius, apparently containing matter. The right knee is still painful, pulse 132, febrile symptoms rather less. In addition to the medicines she was using, she was ordered also nitrate of potass ʒvi. in barley water lbij, to be taken during the 24 hours.

November 2d. She is reported better, the pains much easier, and the erysipelas gone; the jaundice much as formerly.

7th. The pain of the wrist, and tumour of the radius both less; rather

more pain of the right elbow and knee, the forearm mottled blue and yellow, as if the limb had been bruised; slept better; she continued her medicine; no mercurial effect from the calomel. From this time her complaints became considerably aggravated; her sleep was quite interrupted; she took a grain of opium every two hours, without any effect; her stomach became irritable, and she threw up bile; the nitre was discontinued, as it probably had disagreed with the stomach; the infusion of senna was ordered, and the opium to be continued in grain doses every hour; poppy fomentations to the painful parts. From this she appeared to derive relief; she slept better, and she could bear to move the affected limbs. There was still occasional bilious vomiting; she took from 8 to 12 grains of opium in the 24 hours; her bowels were kept open by the infusion of senna; the calomel has been omitted for some days. 18th. She has been tolerably easy since last report; this morning it was stated that she had a miscarriage in the night, the fœtus being about four months, of which condition he had no suspicion. There was now a good deal of febrile excitement, pulse 120 small; the rheumatic pains trifling. Next day there was abdominal pain, augmented by pressure, the febrile symptoms persisting. Ordered fomentations to the abdomen, by means of a bag of bran wrung out of hot water, and of ricini  $\mathfrak{z}$ i. cum. tr. opii  $\mathfrak{z}$ i. These means afforded only very temporary relief, and she passed a restless night, and raved much; pulse 130 small, and not hard; abdomen very tender. Ordered to be cupped on the abdomen, and to have a blister to the nape of the neck. These remedies produced very little effect. She became wayward and uncontrollable; her countenance and conduct indicated mental alienation; her pupils were dilated; pulse 144; tongue clean; her abdomen having been blistered on the previous day, it cannot be ascertained how far the internal pain is better. From this time she appeared to improve a little; her countenance more natural; she did not complain so much of her abdomen; lay on her side, and moved her limbs freely; she, however, was constantly desirous to leave her bed; pulse 144 hard, bowels free. Ordered Tr. digitalis M. viij., and antimon. tartar. gr.  $\frac{1}{2}$  in aqua cinnam.,  $\mathfrak{z}$ i. omni hora. On the 24th she is reported to have slept well during the night, and was much better, and more at ease. She moved her limbs freely; her bowels, still tender on pressure, were freely open; the dejections dark and bilious; pulse 132, small and not so hard. Was ordered to repeat the blister, and to take calomel and opium four times a day. The following day she was much worse, and seemed very low; her pulse rapid, but still of tolerable volume; had passed a bad night, and seemed to complain of abdominal pain on pressure, but it could not be ascertained whether this was not owing to the effects of the blister. She was ordered to be again cupped on the abdomen. She died next day, after I had left Montreal for England. No *post mortem* inspection was made of the body.

REMARKS.—Although erysipelas is usually, if not uniformly, accompanied by a derangement of the biliary function, of which we



have in most cases sufficient indication, in the discoloration of the albuginea, and the state of the dejection, I have never seen so obstinate a case of jaundice associated with erysipelas, upon which a long perseverance in the use of mercurials and purgatives did not seem to produce any very decided effect. The association of erysipelas, and other exanthemata, with rheumatism, has been noticed by Dr. Todd, and some other modern writers, and of which I have met a few of these complications. Two other cases of erysipelas and rheumatism occurred in the hospital, about the time the above case was under treatment. The other eruptive diseases which I have seen associated with rheumatism were scarlatina, roseola, and erythema nodosum. Dr. Todd is of opinion that rheumatism, as well as these exanthemata, depended on some morbid alteration of the blood. His views appear to be favoured by some more recent investigations, and may probably eventually be generally adopted. This association (although, in some cases, it materially complicates and aggravates the case) does not interfere with the appropriate treatment of each. When, however, the three affections become combined, the case then becomes of a very serious nature; and when abortion and puerperal fever become superadded, the prognosis is extremely unfavourable.

There was a further peculiarity in this case, namely, the rare formation of matter, as a consequence of rheumatism; its absorption, I think, may fairly be attributed to the effects of the iodine. A question suggests itself, did the abortion arise from the rheumatism seizing on the uterus? I think we may fairly admit this to be the case, as no other satisfactory cause offers in explanation. She had not been taking any drastic medicine, nor was there any particular aggravation of her complaints at the time.

It is to be regretted that a *post mortem* inspection was not made, as much pathological information might be expected to result therefrom.—*Brit. Amer. Journ. of Med. and Phys. Science.*

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*Production of Sulphurets on Metallic bodies struck by lightning.*—Nothing is more common than to hear, when persons or buildings have been struck by lightning, that there was a strong odour of sulphur in and around the spot. This odour has, however, been generally referred to a partial combustion of organic matter. How an imponderable like the electric fluid can contain, be combined with, or elicit sulphur either from the atmosphere or by some unknown method of synthesis, it is not easy to understand; but M. Bonjean appears to be the first chemist who has proved that sulphur is actually evolved by the effect of a stroke of lightning.

On Sunday, June 14, 1846, a church near Chumbery was struck by lightning. The interior was filled with a thick smoke, and the smell was compared to that of gunpowder. M. Bonjean having been informed that certain gilt articles had been blackened by the electric fluid, examined the place the following day. He found that the gilt frame of a large picture was almost entirely blackened in its longitudinal and transverse portions. Six gilt chandeliers were blackened,

exactly like copper immersed in sulphuretted hydrogen gas; while a cross, gilt exactly like the chandeliers, and placed in the midst of them, had not undergone any change. A portion of the dark film was scratched from one of the tarnished chandeliers, and digested in pure nitro-muriatic acid. The addition of a salt of barytes to the diluted solution indicated clearly the presence of sulphuric acid. It would thus appear that the electric fluid is accompanied with sulphur in some state of combination, probably as sulphuretted hydrogen. If it were sulphurous acid, oxidable metals would be transformed to sulphites and sulphates. The odour, therefore, so frequently observed, is probably due to the presence of the above mentioned gas.

It may be objected that gold is not chemically attacked by sulphureous vapours; but M. Bonjean contends that so far back as 1838, he proved that gold when exposed to the vapour of sulphureous waters, is liable to become tarnished and transformed in the course of fifteen or twenty days, to a sulphuret, like silver, lead, copper, &c. The only difference is, that these metals, being much more oxidable, the reaction caused by sulphur becomes more speedily evident—*Comptes Rendus*.

[M. Bonjean's observation on this chemical effect of an electric stroke, is novel and interesting. We take leave to doubt, however, whether sulphur vapours, under any circumstances, will tarnish *pure* gold. Much of the gold sold for gilding is alloyed with copper, and we apprehend that we have, in the extensive use of this alloy, or in the use of Dutch lead itself, a full explanation of this alleged action of sulphur on gold, in this and other instances. We have known *pure* gold to preserve its polish and brightness in a London atmosphere, where sulphur abounds, for seventeen years. The gold plates used by the Egyptians for covering the features of their mummies, and their mummy cases, is, if we except superficial dirt, as bright as when first laid down, 3,000 years ago.]—*London Med. Gaz.*

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*Cause of the failure of Vaccination in France*—M. Testel adopts the opinion, that the vaccine virus is liable to undergo degeneration, and therefore requires to be occasionally renewed. He thinks, however, that the facts admit of an explanation entirely different from that which is generally received. He endeavours to show that the distinction hitherto made between genuine and spurious vaccination is insufficient, and that an intermediate state exists. He calls this a mixed form of vaccination, in which there is a *preservative power* for a longer or a shorter period, and in a greater or less degree. In his view the vesicle formed under these circumstances, has been hitherto confounded with the true vaccine vesicle, and from this has arisen the opinion that the vaccine virus has undergone degeneration and that revaccination is necessary.—*Lond. Med. Gaz., from Comptes Rendus*.

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*Case of alleged Uterine Respiration*.—In November, 1845, M. Tourtois was called to attend a female in labour, who had already borne several children. The membranes had become ruptured, and



the waters had been discharged about an hour before his arrival. The head was descending into the pelvis, and in attempting to give it a better direction, M. Tourtois introduced two fingers into the child's mouth, when, to his surprise, he felt them sucked or drawn in with some force. Others who were present satisfied themselves of the existence of this phenomenon; and at intervals for more than half an hour, the child, which thus breathed before birth, continued to suck the finger of the accoucheur with great energy. The woman, after some hours, was delivered of a lively female child, which sucked the breast vigorously an hour after its birth.—*Gaz. Med.*

[Admitting that the act of sucking was real, and that air was drawn into the lungs of the child, it will be observed that the rupture of the membranes, the descent of the head, and the introduction of the hand of the accoucheur, all tended to favour the imperfect act of respiration before birth. To apply to it the term uterine respiration, is, under these circumstances, quite inappropriate.]—*Lond. Med. Gaz.*

*The melting point of Phosphorus.*—M. Desains has lately made some experiments on this subject. According to him, most chemical writers state that phosphorus melts at  $109^{\circ}$  ( $104^{\circ}?$ ). In order to determine the temperature of fusion, the phosphorus must be melted under a thin stratum of water; a thermometer should then be plunged into the midst of the melted substance, and when the instrument stands at about  $109^{\circ}$ , it should be well agitated. The phosphorus then solidifies, and the temperature always rises to and remains at one uniform degree, which is the period of fusion and solidification. If the melted phosphorus were not stirred about, its temperature might fall twenty or thirty degrees lower; and then the latent heat evolved during solidification would not be sufficient to make it regain the true melting point. The degree at which the thermometer would remain stationary would depend on that to which the phosphorus had fallen before solidifying, and on the radiation of heat to the surrounding medium. The greater the quantity of latent heat taken by this medium, the less will remain to raise the temperature of the solid. M. Desains has found as the result of his experiments, that the temperature at which distilled phosphorus melts and becomes solid is  $42^{\circ}.2$  centigrade. This is already equal to  $112^{\circ}$  F., a temperature much higher than that which has been hitherto assigned by chemists.—*Ib., from Comptes Rendus.*

*To cover Pills or extract of Copaiba with Gelatine.*—This process, invented by M. Garot, is exceedingly easy and practicable, and it is not employed more generally in this country, as it much more effectually disguises the taste and odour, and interferes less with the solution of the medicine, than the method of gilding or silvering usually practised. It is applicable to every substance capable of a pilular consistence; such as balsam, camphor, musk, assafoetida, mercurial and ferruginous preparations, &c. Two hundred pills can be coated with gelatine in an hour, and will be ready for use after the lapse of

two hours. The pilular mass so coated remains soft for a much longer time than according to any other plan. The process is as follows:—Fix the pills on long, fine pins; plunge them into thick purified glue placed in a hot-water bath; then remove them by a rotatory motion, and stick the pins in paste spread out on a slab, so that the pills may remain elevated in the air; as soon as fifty are thus treated, rotate them individually in the heat of a taper, to harden the external pellicle, pull out the point of the pin, and the process is complete.—*Ib.*, from *Dublin Hospital Gazette*.

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*On displacement of the lower fragment in fracture of the surgical neck, of the Humerus.* BY M. DEBROU.—As fracture of the surgical neck of the humerus is commonly occasioned by direct violence acting on the posterior part of the shoulder or on the upper and outer part of the arm. M. Debrou thinks that the fracture is usually directed obliquely from above downwards, and from within outwards, or from before backwards. In 1843 he saw three cases of this fracture at the Hôtel Dieu of Orleans in which the obliquity was in this direction, and in those three cases there was considerable prominence of the lower fragment, which was drawn upwards and carried inwards and forwards. When the extremity of the lower fragment is drawn in this direction it encounters a smaller thickness of soft parts than if it were displaced externally, and may come in immediate contact with or even run the risk of perforating the skin. In the three cases above referred to, the extremity of the bone partially (but not completely) perforated the skin, and thence carried the integument backwards with it on the slightest motion of the elbow and of the inferior fragment; from this there resulted a depression of the skin, which became deeper the further the lower fragment was carried backward. In one of these cases the lower fragment was so firmly engaged in the skin that perfect reduction could not be effected until the bone was freed from the skin by means of a subcutaneous section with a tenotome introduced two inches from the site of the fracture.—*Dub. Med. Press*, from *Jour. de Chirurgie*.

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*Resection of the four external fifths of the Clavicle.* BY M. CHAUMET.—Marie Clermontel, æt. 18, was admitted into the Hôpital St. André of Bourdeaux, June 30, 1845. Nine months previously she expressed vague pains in the right clavicle. A tumour soon commenced which has attained the size of the shut hand; it is immovable, hard, mammillated, and occupies nearly the four external fifths of the clavicle: it is the seat of moderate pain, and does not impede the motions of the right arm, which is not, however, quite so strong as the opposite one. July 15th M. Chaumet laid the tumour bare by a semi-elliptical incision, convex anteriorly and inferiorly, which extended from within half an inch of the sterno-clavicular articulation to the summit of the acromion. After dissecting up the flap, a portion of which was removed, as its size would have interfered with coaptation of the parts after the removal of the tumour, a vertical incision



was made at the sternal extremity of the first along the inner border of the sterno-mastoid muscle. The tumour was then detached from its connections without its being necessary to tie a single artery. The clavicle was now divided at its internal fourth with the chain-saw, and the coraco-clavicular ligaments being cut, the bone was removed. Three points of suture were applied, and to diminish the extent of the cicatrix, the shoulder was approximated to the residue of the clavicle by a circular bandage. Irrigation with cold water was commenced two hours after the operation, and continued till the tenth day. On the 54th day the remains of the clavicle was slightly elevated by the sterno-mastoid muscle. On the 70th day the girl returned home, enjoying slight motion of the arm.—*Ibid*, from *Journ. de Med. de Bourdeaux*.

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*Two cases of imperforate Hymen.* BY MM. DE BAL AND KLUYSKENS.—*Case 1.*—A girl, aged 18, consulted M. de Bal in February, 1844, for symptoms referred to painful menstruations, and again applied to him the following May. She had then grown thin, and suffered intolerable pain in the kidneys and left hypogastrium; the womb, felt through the abdominal parietes, had the size and consistence it presents at the sixth month of pregnancy. There was continued fever, obstinate vomiting, and the countenance was of a pale yellow colour. These symptoms had at first recurred periodically every fifth week, then ever fourth and third week, but had been continued for the last three weeks. On examination M. de Bal found that the vagina was totally absent, and felt a hard, fibrous, voluminous body through the rectum, not very moveable, but moving with the uterus, and giving the sensation of the presentation of the head of a full grown fœtus. With the finger in the rectum and a catheter in the bladder, M. de Bal ascertained that the distance between the most depending point of the tumour and the point where the orifice of the vagina should exist was two-and-a-half inches, and that to the depth of an inch and-a-half there existed between the bladder and the rectum merely a fibrous cord from one-and-a-half to two lines thick.

On the 23rd of May the bladder and rectum having been emptied, a catheter was passed into the bladder, and M. de Bal introduced his finger into the rectum. A transverse incision was then made between the anus and urethra with a bistoury guarded with lint except at the point, and carried in the direction of the fibrous cord to the depth of one inch four lines, and advancing with suitable precaution, a point was attained where there was a greater interval between the rectum and the bladder. A common trocar was then plunged into the dense tumour whose parietes were three or four lines thick. On withdrawing the stilet a pint and a-half of thick viscid inodorous fluid, resembling well boiled syrup, escaped. The tumour diminished on the instant and descended at least two inches. The cavity was washed out with injections of tepid water, and a gum-elastic canula was left in the wound. Every attempt to dilate the wound failed, an invincible resistance having been experienced especially at its upper third. The

patient recovered perfectly, and has menstruated regularly since the operation.

*Case 2.*—A, B. had not menstruated at the age of 18. For the last fifteen months has experienced pains resembling colic, which first recurred at long intervals, then every month, every fortnight, and finally, every day. The abdomen became swollen, the pulse were small, frequent, and she was affected with borborygmata and hysteric symptoms. After having in vain tried several remedies, the patient, pallid and exhausted with suffering, consulted M. Verbeeck, who discovered in the abdomen, which was as large as at the full term of pregnancy, a hard smooth tumour ascending to the umbilicus. The valve was well formed, but there was no trace of the vaginal orifice. With a catheter in the bladder and the finger in the rectum, a slender cord alone was found to intervene between those two organs. As death seemed inevitable unless relief was obtained, M. Kluyskens determined to attempt creating an artificial passage. With similar precautions to those taken in the foregoing case, an incision was carried to the depth of three inches, when, on passing in the finger, no tumour could be felt. The incision was carried an inch deeper, when a tumour, supposed to be the womb, was felt, but the os uteri could not be distinguished. The position of the tumour having been well ascertained, a free incision was made into it with a sharp-pointed bistoury guarded with lint to near the point. Upwards of five pounds of viscid blood then escaped, and the tumefaction of the abdomen subsided. Everything went favourably till the tenth day, when inflammatory symptoms set in which caused metritis to be apprehended, but they yielded to antiphlogistics. A gum-elastic canula was introduced from time to time, and in five weeks the patient had perfectly recovered.

Several years have elapsed since the performance of this operation, and the artificial passage has remained permanently open; the patient, who has married, but has no children, enjoys good health, and has menstruated regularly and without pain, but in the intervals is subject to copious leucorrhœa.—*Dub. Med. Press, from Gaz. Med. de Paris.*

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*On a new variety of the dislocation of the Humerus.*—By PROFESSOR ROSER, of Tübingen.—The professor discovered in a subject intended for dissection at the University of Tübingen, a variety of dislocation of the humerus not hitherto described by any author. The head of the humerus lay in front of the short head of the biceps; the sub-scapular muscle was ruptured and completely detached from the lesser tuberosity of the humerus, and the head of the bone elevated the scapular extremity of the pectoralis minor. In ordinary dislocations of the shoulder, the upper extremity of the humerus lies immediately on the outer border of the scapula; in this dislocation it separated from it by the biceps and the coraco-brachialis, whose tendons pass behind instead of in front of the humerus. On a careful examination the following dispositions were observed.

The dislocated limb was abducted and slightly everted, the head of



the humerus touching the inferior border of the coracoid process. Intimate adhesions existed between the muscles of the shoulder and the ligamentous apparatus of the joint. The brachial plexus was surrounded by a very dense cellular tissue. The sub-scapular muscle, detached from the lesser tuberosity of the humerus, terminated in a bulbous mass which rested on the neck of the scapula, and involved the musculo-cutaneous nerve. The head of the humerus lay in a capsule of new formation below and internal to the coracoid process, was tolerably moveable, and the pectoralis minor was expanded over it, adhering very firmly to its capsule. The tendons of the coracobrachialis and short head of the biceps descend behind the head of the humerus involved in the capsule. The long head of the biceps was entirely displaced from its groove, described a curve round the head of the humerus, and was completely adherent to and confounded at its insertion with the fibrous tissue which filled the glenoid process.

The subject of this observation had fallen seven years previously while carrying a heavy load up a hill. The first attempts at reduction were made by some wood-cutters who came to his assistance.—Several surgeons to whom he applied on the following day were equally unsuccessful. Very forcible tractions and several methods, including that of De la Mothe, were tried, but every time that the head of the bone was thought to be reduced it was found to be still displaced. The patient regained tolerable use of the limb, being able to dig and thrash, but could not put his coat on the left arm. He often experienced pain and a sense of numbness in the fingers.

Professor Roser easily produced this species of dislocation on the dead body, by cutting the tendon of the sub-scapular muscle, displacing the long tendon of the biceps from its groove, and then forcing the head of the humerus downwards. But what (he asks) was the obstacle to reduction? It was not, he thinks, muscular action, but the interposition of the short head of the biceps between the head of the humerus and the glenoid cavity. To reduce this dislocation, the same principle should be adopted that is followed in other reductions—viz., to cause the head of the bone in re-entering to follow the course it took in its exit, and as while being displaced it probably sustained violent torsion outwards, during reduction it should be forcibly rotated inwards, so as to slide over or else displace the interposed soft parts.

*Ibid, from Archiv.für Physiologie Heilk von Roser.*

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*On breaking and bending of Lithotritic Instruments.* BY M. CIVIALE.—M. Civiale, after noticing the recorded cases of those accidents, considers what is the practice that should be adopted in such cases. When a portion of the instrument is completely detached and falls into the bladder, the event is by no means so formidable as when the instrument is only partially broken. In the former case the patient sustains no immediate suffering—immediate interference is not essential, and as may be indicated by circumstances, attempts may be made to extract the metallic fragment, or the operation of lithotomy may be performed at a fitting opportunity. But when the instrument

is but partially broken, when the bent lithotrite cannot be withdrawn from the bladder, immediate interference is necessary; and surgeons have hitherto generally endeavoured to withdraw the instrument where the urethra has been lacerated or contused. M. Civiale in such cases recommends that the high operation for the stone should at once be performed, the surgeon having of course previously furnished himself with the instrument requisite to remedy the distortion of the lithotrite that prevents its being withdrawn, and then any bending may be corrected, a half-severed fragment may be entirely detached, or, if needful, the portion of the lithotrite in the bladder may be sawn off. The lithotrite itself being in the bladder will facilitate the performance of the operation.

M. Civiale strongly deprecates, as not only useless but injurious, attempts to withdraw the lithotrite, (which have been so frequently made by surgeons under such circumstances,) ignorant as we must of necessity be as to the nature and situation of the obstacle. Even when the instrument is brought into the membranous portion of the urethra, it may be utterly impossible to withdraw it further, as other parts of the urethra are not equally dilatable. He also condemns cutting down on the lithotrite in the perineum, as the bent part of the instrument may not be thus attainable. M. Civiale recommends that, in addition to the surgeon always himself testing the strength of lithotritic instruments before operating with them, the instrument should be so constructed that the surgeon cannot exert more than a certain moderate degree of force with it—an object easily effected by adjusting the power and construction.—*Ibid*, from *Bulletin de Therapeutique*.

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*Poisoning by Arsenic.*—The widow M——, and Antoine B—— were recently tried at the assizes of Herault for the double crime of adultery and poisoning the husband of the female prisoner. The facts, as they appeared in evidence, were as follows:—In August, 1844, shortly after several violent quarrels between M—— and his wife, caused by the intimacy between the latter and B——, and just at the period when B——, because of the consequent scandal, had lost his only means of subsistence, M—— fell sick. The symptoms of his malady were shiverings, cold perspirations, great itching in the extremities, and at length considerable emaciation. As no suspicion was then excited, and as the symptoms presented periods of subsidence which simulated intermission, they were considered as the effect of accesses of fever, especially as intermittent fever is endemic in the locality, and his wife was actually labouring under that disease. The wife, becoming convalescent, paid a visit to her family, and during her absence, her husband, whose malady had been so serious that he sought for the consolations of the church, became convalescent also. On the return of the wife the husband's malady again became aggravated, and continued until the vintage, at which period the wife again left home to superintend some matters of business, and during her absence, which continued a fortnight, the



husband's health was so far re-established that he was able to look after his affairs. His physicians then considered that he had only to continue the prescribed regimen to become perfectly restored to health. From this period M—— continued in the country with his wife, but his convalescence, instead of being progressive, was suddenly interrupted. For a few days he felt tolerably well, but then his former sufferings commenced to return. New symptoms were also gradually superadded; vomiting occurred several times, and the wife on each occasion threw the ejected matter out of the window. On one occasion M—— vomited on the floor, and the wife scattered ashes on what was thrown from the stomach, and subsequently washed the floor with potash.

Nothing as yet, however, indicated that M—— was near his death. Early in December he attended to his affairs as usual; but on the 5th of that month, after a short walk, he became chilly, and took to his bed in the afternoon. From that moment his wife never left him, and no one else entered his chamber.

On the 6th December M—— died, no one being present, says the wife, who informed the inmates of the house that her husband had just expired tranquilly, and without convulsions. The inferior extremities, however, were found contracted, the body was already cold and cadaveric, rigidity so great that it was impossible to remove the clothes completely.

Some vague suspicions at first existed, but soon subsided, until they subsequently became revived and strengthened from a train of circumstances unnecessary to be detailed. The authorities then directed the body to be exhumed, when the usual fact was observed, that the extremities were completely decomposed, while the parietes and viscera of the abdomen, which usually putrefy first, were in a state of perfect preservation. This circumstance, together with the existence of some yellow stains, such as might be produced by the action of certain products of putrefaction on a compound of arsenic, raised a suspicion that M—— might have been poisoned by such a substance. This suspicion was converted into a certainty by chemical analysis. Arsenic was detected in the intestines, in the liver, in the spleen, in the kidneys, in the bladder, in the heart, in the lungs, in the muscles of the stomach and of the abdomen, as also in the liquid contents of the hollow abdominal viscera.

As M—— had vomited several times, and his wife had disposed of the material vomited by throwing it from a window, and washing the floor, arsenic was sought for in those situations. The soil in the immediate vicinity of the window and also at a certain distance from it, was collected and analysed, as were scrapings from various parts of the floor of the chamber. Arsenic was detected to a marked amount in the soil collected next the wall immediately under the window, and also, but in a much smaller quantity, in that collected within the space of 8 or 10 feet from that point. All the scrapings from those parts of the floor which were stained with the material rejected by

vomiting yielded arsenic, but not a trace of that substance could be detected in those taken from other situations.

In anticipation of a system of defence, which was actually adopted, some earth taken from above, from beneath, and from each side of M——'s coffin, was analysed, and was found to be completely exempt from arsenic.—*Dublin Medical Press from Gazette Medicale.*

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*Absence of Arsenic in the Fœtus, the Mother having been Poisoned by Arsenic.*—In a recent case in Belgium, arsenic was detected in the fœtus carried by a female, who had been poisoned by arsenic. M. Benoist of Amiens, lately communicated to the Society of Pharmacy of that town the following case, in which the contrary was found to be the fact.

M. Benoist was charged with the examination of a young woman six months pregnant, who had poisoned herself by swallowing a considerable quantity of arsenic. The results of all his experiments perfectly demonstrated the cause of the mother's death. Not only was arsenic detected by means of Marsh's apparatus, but the poison was collected in substance on the internal surface of the stomach, and readily reduced to the metallic state.

The fœtus was at the sixth month of development, and was carefully examined in order to ascertain whether it had died in consequence of absorbing the poison which had destroyed the mother. All the experiments with Marsh's apparatus, however, gave a negative result. The combustion of the gas yielded by the apparatus was continued for upwards of an hour without obtaining a trace of arsenic.—*Ibid from Ibid.*

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*On the formation of Abscesses external to the Bone after fractures by contre-coup of the Long Bones and compound luxations.* By M. LAUGIER.—In the last number of the *Archives G n ral s*, M. Laugier has published a memoir under the foregoing title :—When in a luxation or a fracture the articular extremity or a fragment of the bone perforates the skin, it might be supposed that the greatest injury to the parts would be inflicted, and the chances of suppurative inflammation be greatest on the side where the integuments are perforated; but on the contrary, when an abscess forms, it is constantly on the opposite side. This M. Laugier explains as follows :

On examining the extent to which the soft parts are separated from the surface of the bone on the side towards which the displacement occurs and on the opposite side, it will be seen that the separation is always greater in the latter situation, especially in displacements by *contre-coup*. Thus, to take a particular case, fractures of the leg by *contre-coup* usually occur at the union of the lower and the middle third of the tibia, and are generally oblique outwards, and from above downwards. Suppose the upper fragment of the tibia, in such a fracture, perforates the skin and protrudes internally to the extent of an



inch, on examining, before the fracture is reduced, on what side of the bone the disturbance of the soft parts is most extensive, it will be found to be so on the outer side of the bone. Doubtless on the inner side the integuments are perforated and the bone projects, but the soft parts remain adherent to the bone above the portion which actually projects. On the external surface of the bone, on the contrary, the separation of the soft parts from it and the laceration of the cellular tissue will have occurred to the extent of from two-and-a-half to three inches when the bone projects one inch through the skin. This approximative estimate, it will be easily seen, could be made with almost mathematical accuracy were such precision necessary. The separation of the projecting fragment from the muscles with which it is naturally in contact, is measured by a pyramidal space whose summit is above and base below, represented by the thickness of the tibia at the seat of the fracture, and whose height is two or three inches. If reduction is not immediately effected, immediate union is impossible, and protracted suppuration occurs. After perfect reduction there will be internally a kind of cavity, bounded below by the bone and superficially by the skin; but the skin being perforated, there can be no accumulation of matter if the wound remains open, and if it becomes united and pus accumulates under the skin it will often escape by causing the wound to re-open, or if it does not, its presence is at once perceived and artificial exit is easily given to it. On the external side of the bone, on the contrary, if the separated parts do not immediately unite, the suppuration tends to increase the extent of their separation, and the pus, instead of escaping externally, even when the wound is open, spreads along the tibia, forming an extensive abscess, which is usually not perceived for some time.—*Ibid* from *Ibid*.

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*Case of Rupture of the Bladder: Recovery.* By WILLIAM CHALDECOTT, Esq., Surgeon, Dorking.—(Read at the Annual Meeting of the South-Eastern Branch of the Provincial Medical and Surgical Association, June 24, 1846.)—The records of surgery exhibit so few instances of recovery after rupture of the urinary bladder, that probably the details of the following case may not be unacceptable to the members of our Association, affording as they do encouragement to both surgeon and patient to hope under circumstances that have generally forbid any other than the worst anticipations.

At 12 o'clock on the night of Tuesday, the 7th of April, Mr. John Philps, a wine-merchant in Dorking, a healthy and temperate man, of about fifty, having passed two or three hours at a concert, ran across the street to empty his distended bladder, and the night being dark, he did not see a newly-erected post, with the top of which the lower part of his abdomen came in violent contact. He states that he fell, and with great difficulty reached his home, which was about a hundred yards distant.

I saw him about half an hour after the accident. He was faint,

and suffering severe pain over the stomach and belly, with desire but no power to pass his urine. I ascertained that none had escaped into his clothes, and my suspicions as to the nature of the mischief, were confirmed by the circumstance of nothing escaping through a full-sized catheter which was passed easily and completely into the bladder. He was placed in bed, and hot fomentations were used to the belly until re-action took place, with which came increase of pain over the stomach and abdomen. Twenty leeches were also applied, and I now passed a gum catheter, but with the same unsatisfactory result as before, not a drop of urine escaping through it. I wished to have left the instrument in the bladder, but to this the patient strongly objected, and I urged it the less from some apprehension that in his restless movements the point might be forced through the wound in the bladder; the catheter was therefore passed every three or four hours, although up to two o'clock, p. m., fruitlessly.

I apprised the friends of the patient of the nature of the injury, and the extreme danger attending it, and in consequence Mr. Key was sent for. He arrived at six o'clock, which was about eighteen hours after the accident, by which time the symptoms of peritonitis had increased to an alarming degree. The belly was painful, swollen, and tender; the pulse rapid and feeble, and the countenance anxious. Mr. Key passed a catheter, (none having been used for the previous four hours,) and about an ounce of bloody urine came through the instrument. Mr. Key concurred with me in his opinion as to the nature of the injury and the nearly hopeless prospect for the patient.

At ten o'clock I gave him two scruples of liquor opii sedativus, which after a few hours produced some comfortable sleep, and about four hours from the time of Mr. Key's visit I again passed the catheter, and drew off about four ounces of clear urine. From this time, the pain, swelling, and heat in the stomach and abdomen gradually lessened, and it was evident that the bladder now held, as on each introduction the catheter brought away clear urine.

From this time until the 13th, (that is the sixth day from that on which the accident happened,) all went on well, excepting that a smart attack of gout occurred on the 10th, although the patient had never before suffered one; but on the 13th, from a strong desire to become independent of the catheter, he made straining efforts to pass his water, and he had scarcely passed a tablespoonful, when he felt (to use his own expression,) something give way, and a burning pain all over his stomach and bowels, as if boiling water had been poured over them, and the same symptoms of faintness and distress occurred as when the accident first happened.

I saw him within a few minutes of this re-opening of the wound of his bladder, for I could not doubt but such had been the consequence of his attempts to pass his water. On using the catheter, not more than a teaspoonful came through the tube. He had now again the symptoms of peritonitis, with the addition of incessant



sickness. The same plan of treatment was again adopted—viz., fomentations, leeches, and a full opiate, with calomel.

About four hours after, on the introduction of the catheter, the bladder was again found to retain its urine; and although the peritonitis had increased to a severe degree, the pain, tenderness, and sickness, gradually subsided; and by a patient submission to the continued use of the catheter for a fortnight, no more interruption to the patient's amendment occurred, excepting that the gout, which, under the use of colchicum, had nearly disappeared, again became severe, no doubt, from the fresh absorption of urine which this second accident had permitted to escape into the cavity of the peritoneum. But by this time it was presumed that the wound in the bladder had closed with sufficient firmness to allow the patient to yield to the desire to evacuate his urine without any straining efforts.

Two months have now transpired since the commencement of the case, and he feels no other inconvenience from his accident except a dragging sensation over the abdomen, chiefly on the right side, which is much increased when he attempts to lie upon his left side. This no doubt results from adhesions, consequent upon the peritonitis.

*Remarks.*—The manner in which the accident happened, and all the circumstances and symptoms which followed it, were to me conclusive of the nature of the mischief. If anything could suggest a doubt about the rupture of the bladder, it was the very circumstance which makes the case remarkable—namely, the recovery; but to one who watched the case, no such doubt could occur, since it must be recollected that the bladder was known to be full at the time of the accident, no urine escaped into the clothes, nor did any come through the urethra for more than eighteen hours after, and then only about an ounce, mixed with blood. If, therefore, it did not escape into the cavity of the peritoneum, what else could have become of it?

This case may range with many, in proof of what severe injury the peritoneum may sometimes sustain, and the patient yet survive. Indeed out of the evil of peritonitis, which usually renders this accident fatal, came the good of such an effusion of lymph, as no doubt glued the bladder where wounded to the contiguous viscera.

The fact of gout occurring upon the absorption of urine which first escaped into the peritoneum, and its aggravation upon its second extravasation, is interesting as connected with the pathology of that disorder.—*Prov. Med. and Surg. Journ.*

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*Observations suggested by two Cases of Loss of Language.* By THOMAS CHAMBERS, M. D., late Physician to the Chelsea Dispensary.—Disease affects the intellectual powers in two ways, either by adding perverted function, or subtracting healthy function. On reviewing the classes of cases which come under these two categories, it will be observed that the causes of perverted action are usually to

be sought in a part distant from the great centre of the mind's operations, while diminished or abolished action rightly leads us to suspect material change in that part. The unfounded fancies of the hypochondriac, and the excited imagination of the hysteric, refer us, by their names, under the ribs, or down in the pelvis, for information on their causes; in delirium traumaticum

"the pure brain  
Does, by the idle comments that it makes,  
Foretell the ending of mortality."

In these cases from a distant cause, perverted function is added to the "pure" brain. On the other hand, when function is subtracted, we may usually conjecture some defect in the nervous centre; the deficiency of reasoning in the idiot is usually joined with malformation of the brain so marked as to affect the external appearance; "they have," as Fuller says, "heads either so small that there is not room for much wit, or so large that there is not wit enough for so much room." Now the manner in which another intellectual power, the memory, is affected, does, I think, sometimes serve as a means of diagnosis in certain obscure cases of cerebral disturbance which, from other symptoms, we do not know whether to ascribe to the slow supervention of delirium tremens or to chronic disease of the brain. The causes and cure of the former disorder are certainly not local. Now, under its influence the memory conveys impressions, but conveys them falsely; a man, for example, will remember that some well known crime has been committed, but remembers falsely that he himself was the perpetrator. Where, however, there is actual loss of memory, oblivion on some point, it may give a strong presumption that the mischief in the brain is more than functional. It did so in the following case, which, after this preface, I will transcribe.

Christian B., a German bootmaker, during the winter of 1842, used frequently to bring his sick child to me, and I often saw it at home, so that I had an opportunity of knowing his habits of mind and body. He was sober and intelligent, but a bad English scholar. In February, being disappointed in his hopes of success in trade, he became morose and dejected. At the beginning of March his wife came to me, stating that her husband had lost the use of his native language, but, what much surprised her, was still able to express himself in the little of ours that he knew. I did not take as a proof of this merely his not understanding my bad German, but could credit the report of his wife, who spoke it perfectly. This symptom was intermittent, as occasionally he seemed as capable of conversation, and as rational as usual. He complained, by signs, of pain in the head, and confusion of thought. The bowels were costive, the pulse rapid but soft, and the tongue creamy. There was a feverish heat of skin, but it was at all times moist, and occasionally bathed in copious perspiration. A rapid and trembling action of the hands in taking hold of anything, and a peculiar precipitate manner of putting out



the tongue, bore a striking resemblance to what we see in delirium tremens. Though very morose and snappish in general, he was occasionally, without cause, joyous and easy, and always seemed glad to see me. There was no intolerance of light, and he was rather pleased with looking out of window. He was cupped, purged, and took small doses of mercury, and had cold lotions to the shorn scalp, with some slight benefit. The resemblance of the symptoms to delirium tremens I thought justified an attempt to remove the sleeplessness by morphia, but it did not appear beneficial. His wife, being in constant alarm for her children, had him removed to a lunatic asylum, where at first he seemed better, but, after six days, he suddenly became worse, and died so rapidly (apparently from asthenia,) that they had not time to inform his friends of his dangerous state before his death. The body was brought home, and, assisted by Mr. P. Hewett. I examined the head on the 23d of March. The subarachnoid cellular tissue of the vertex contained some clear fluid and the veins were somewhat congested. The substance of the brain was firm and healthy. The lateral ventricles contained no more fluid than is natural, but their membrane was slightly opaque. The arachnoid of the fourth ventricle had lost its glossy surface, and appeared as if sprinkled with fine grains of transparent sand: that also which covers the medulla oblongata was perhaps rather opaque. There appeared enough to justify us in attributing the man's death to inflammation of the arachnoid, and not to delirium tremens—an opinion which, before death, it would have been difficult to absolutely pronounce.

The peculiar symptom which caused me to relate this case, namely, the forgetfulness of his native tongue, whilst a strange one was retained, has at first a mysterious air. I think, however, we may in a great measure explain it by supposing that the more complex ideas, to express which he was accustomed to use the language he understood earliest and best, were lost; while the simpler and sensualler ones, which he could put into English, were retained. It was perhaps a partial lesion of memory, rather than a lesion of a peculiar class of ideas.

Many instances, however, are on record of such lesions of peculiar classes of ideas, while the rest of the intellectual faculties remain perfect; and, from the striking nature of these cases, they excite so much attention as to make them seem more common than they really are. The following was a remarkable one in point, where, from other symptoms, there was no doubt that there was material change in the brain itself, though the confirmation by actual inspection was wanting.

Harriet C., æt. 12, had typhus fever in December, 1845; she had much delirium and low symptoms, but, as is usual with children, soon got about again, and was able to return to school. However, after a few days' attendance, she was one evening, on returning thence, taken with a fit, of an undecided epileptic character, had rigors, and was again delirious. The delirium was monotonous, and remarka-

ble for her constant repetition of the word "sinner" with every variety of intonation. Wine and bark were, as during her former attack, resorted to, but symptoms of slight effusion in the brain caused its suspension. She recovered after a few weeks so as to be up and dressed, but with the loss of power to pronounce any word except the one she had so often repeated during her fever. This she made serve to express all her ideas; for denial she shook her head and said "sinner;" assent was expressed by the same word, and bread and butter was called "sin-un-sinner." She perfectly understood all that was said to her, and appeared capable of reading her usual lessons. Blisters were applied behind her ears, and small doses of mercury administered, and at the same time her mother and family were instructed to teach her as they would an infant to talk. I also took opportunities of showing her, by exaggerated motions of my mouth and throat, the way of forming the letters, in the manner in which the born deaf and dumb are instructed, and found her intelligent and ready. She soon acquired the word "yes," and other elementary expressions, and by the end of the spring was able, as her mother told me, "to talk like an old woman." Symptoms of consumption had, however, appeared, and she died this last summer under the care of another medical man, whose kind efforts to obtain a post-mortem examination for me were unavailing.

The instances usually cited of the loss of memory on special subjects are where it has been the consequence of blows or some such external injury to the head; still both it and general loss of memory will occasionally follow typhus fever. In some epidemics it has done so with such marked frequency as to form one of the characteristics of the prevailing disorder. This was the case in the great plague of typhus which followed the famine at Athens in the Dorian war, as we learn from Thucydides (book ii. cap. 49,) where he tells us that of those who recovered, some entirely lost the recollection of their former associates, and some even the idea of their own personal identity. The symptom is an unfavorable one at all times, as showing that material mischief is done to the brain, but it is much less unfavorable when a consequence of fever, than where, as in the case of the German bootmaker lately cited, it commences the illness. The history I have related is sufficient to show it to be curable.—*London Medical Gazette.*

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*Medical Schools in London, for 1846-7.*—To judge from the announcements which have been made through our advertising columns for the last three weeks, it would appear that the postponement of the medical reform measures has had very little influence on the Schools. The number of these, although more than sufficient for the wants of the profession, is nearly as great as at any previous period; and if a few "professors" have disappeared from the scenes of their former labors, their "chairs" have been filled with a facility and rapidity which would lead to the supposition that the outcry re-



specting the ill-paid services of medical teachers, is quite unfounded. Prizes in the shape of gold, silver, and bronze medals, testimonials of honour, and scholarships, are announced among the good things to which the student has to look forward as the reward of industry : and some of the metropolitan and provincial schools vie with each other in the rich promises thus held out to the youthful aspirants for medical honours. In our judgment this system is carried too far : these prizes, by the profusion with which they are bestowed, are too frequently made to serve as a meretricious bait to attract students to particular institutions. If the benefits to be derived from instruction at a school, were always proportioned to the number and value of medals, &c., distributed, there might be some reason to defend the system ; but it is well known that they too often serve as objects to allure persons to schools which are entirely deficient in the means of practical instruction. We have heard of one establishment where the prizes were as numerous as the students ; in fact, there were no blanks ! This system leads to a degrading kind of competition among medical schools, and has the injurious effect of creating a special class of students under the name of prizemen, who work rather to obtain these glittering baubles, than to acquire a sound knowledge of their profession.

The reform of the medical profession must begin with a sweeping reform in the present system of medical tuition. Apprenticeships, whereby under an act of Parliament students were compelled to waste some of those years which were best adapted for preliminary education and the acquisition of elementary professional knowledge, are now all but abolished. One medical school has this year adopted the novel practice of including classics, mathematics, indentures of apprenticeship, &c., in a general fee ; and indeed the exact sum required to convert a man into a surgeon and apothecary, is now made as much a matter of certainty as the purchase of a government annuity ! Apprenticeships have not been for a long time practically enforced. They are nominally entered into, but by a mutual arrangement the student commonly finds the means of including the three years' term of medical education, in the period assigned to the apprenticeship.

A student is thus thrown young upon the stage of professional study, and unless he have a parent or relative in the profession, the choice of a school is commonly left to himself. Much of his future success depends upon the selection which he may make. He may meet with bad teachers and bad associates—he may enter himself to an “establishment” such as the defunct Sydenham College, which in its day, judging by the exterior, consisted of two coffee-shops thrown into one ; yet here was an attractive name—a “College”—the “chairs” were filled by “professors” in the respective branches of medical science, the fees were usually low ; and there was a flood of prizes announced for distribution at the termination of the medical session ! It is creditable, however, to the good sense of the class of medical students, that allurements of this kind generally fail to pro-

cure that support which is essentially necessary to the maintenance of such establishments.

A *medical* school without a hospital or infirmary attached to it, is necessarily deficient in the means of practical instruction ; and under a proper system of medical education, this form of theoretical instruction, however good it may be in some rare cases, should, in our opinion, be entirely abolished. Some branches of medical science may, it is true, be taught in establishments unconnected with hospitals ; but the practice has the evil effect of compelling a student to follow two sets of teachers, and entirely neglect either his lectures or the wards of the hospital. We are satisfied, from a long acquaintance with students, that there can be no worse plan than that of attending lectures at one institution and hospital practice at another ; hence, in the selection of a school, they should especially observe whether it be or be not provided with a hospital or infirmary capable of furnishing efficient practical instruction. They may be well assured that no excellence in teachers, apart from a ready access to the wards of a hospital, will recompense them for the deficiency. Upon the choice of a hospital it is unnecessary for us to make any remark. Among the many excellent institutions of this kind which now exist in London, it matters little which a student may select ; for there is no hospital school which is not amply provided with the means of giving sound practical instruction.

On one point, however, we wish to offer a word of caution. Medical education has of late years unfortunately assumed the character of commercial speculation. Competition has been carried to that degree, that in some instances it is quite certain, from the lowness of the fees charged for attendance, there can be no remuneration for the proper performance of the duties. The courses prescribed by the Colleges and Halls are guaranteed at a certain low sum in one payment ; but it is clear that, unless there be a very large number of students in the school, there will be a great temptation to laxity and neglect on the part of the teachers ; and although a low consolidation fee for a three years' course of study may operate as a great inducement to enter to a particular school, yet the student may find in the end that he is paying only for printed certificates, and that if he really require to be instructed in his profession, it will be necessary for him to go elsewhere. True economy will therefore be found in selecting a good and efficient school in the first instance.—*Ibid.*

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*Report of a case of Triplets.* By JOHN F. HAMMOND, M. D., of Silverton S. C.—Mrs. S——, was taken with symptoms of labor, August 26th, at 5 o'clock, A. M. I was called to her at 4, P. M., and found, lying on a pallet, a woman above the average size, bilious temperament, and who had had nine well formed, healthy children. Having been in labor for thirteen hours, and in the care of a colored midwife, she was necessarily discouraged, and the uterus had begun to flag, though not from want of capability. I found all else in an



admirable state; pulse good, head clear, bowels just evacuated, bladder empty; the vertex in the first position, (Velpeau,) and the os tincæ fully dilated; the bag of waters projected largely into the vagina. A few words revived her spirits and restored her energy; she was placed upon her side. I ruptured the membranes with my thumb and finger nails, which, from their toughness, I found very difficult to do, and a few minutes after six o'clock, the second stage (Dénman) was completed; she gave birth to a fine boy. He was removed, and a second was found presenting by the breech, in the fourth position; the bag of waters soon formed and was ruptured, and at half-past seven she was delivered of a girl; the head passing in the second position, the change occurring spontaneously, there was no necessity for interference. Up to this time there was not a drop of hemorrhage, except from between the ligatures around the cords when the cords were severed. On examination, a third fœtus was discovered in the first position of the breech. There was now an intermission of the pains of some minutes' duration, and their recurrence during the remainder of the labor was less frequent, though not less protracted; and though wearied, she was cheerful. Giving time for the bag of waters to form, it was ruptured, the breech passed, and the shoulders with the trunk carried over the mother's abdomen, two fingers against the occiput, and two eliciting it upon the upper maxillaria, the head was delivered in the first position before eight o'clock, after full half a minute's compression of the cord in passing the inferior strait. The cord was unusually short. A little hemorrhage followed. The uterus being free of all but the placenta, the saturated vinous tincture of ergot was given freely, kneading, cold wet cloths, compresses and a bandage were employed on the abdomen and gentle traction by the cords; blood was flowing, though not copiously; the foot of the pallet was elevated by pillows, her head lowered; the placenta perfectly attached to each other, passed into the vagina and from the vulva in about forty minutes after the delivery of the last fœtus. The ending of the third stage was followed by a profuse flooding, which in a few minutes prostrated the patient almost completely. By the former means and titillation of the uterus, it contracted rapidly; she rallied, the pulse revived, and in a few minutes she was carefully placed in bed, with her hips elevated. The sixth of a grain of sulph. morphia soon induced a quiet sleep, and another dose relieved a few pains which came on in the course of the night. The next morning, she was doing well; had slept well—but little discharge. The children are all well. The following are their several weights:—1st male, 5 lbs.; 2d, female, 4 lbs.; 3d, male, 4 $\frac{3}{4}$  lbs. Total, 13 $\frac{3}{4}$  lbs.

These weights appear small, but upon re-weighing, they were found correct. The 1st of September, being the 7th day, mother and children were all doing well.

NOTE.—The extreme rarity of triplets, and the great particularity with which Dr. Hammond describes the process of parturition in this case, renders the above communication very interesting. Triplets

do not occur oftener than about one in six thousand cases. The late Professor Dewees, in his extensive practice in the city of Philadelphia, met with only one case. We only know of two cases ever having occurred in this city—one in the practice of the late Professor Antony, some twenty or twenty-five years ago—the other, in the practice of the present Professor of Midwifery, in 1837: in the latter case, the heads of the second and third child became locked in their passage through the pelvis, and were expelled together. An account was given in the 2d volume, 1st series of this Journal, p. 180.—Eds.

*Med. and Sur. Journal.*

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*Successful removal of portions of Bone, (probably the pubis,) with a large calculous mass from the bladder.* By PAUL F. EVE, M. D., Prof. of Surgery in the Medical College of Georgia.—In January last, I received a letter from an intelligent physician of this State, who mentioned that while on a recent visit to Alabama, he had seen a negro woman laboring under symptoms of stone, and that he had recommended her to be sent to my Infirmary. Upon the arrival of the patient on the 8th of this month (January), the following history of the case was obtained. She is now twenty-four years old, is married and has borne one child: is of good constitution, well made, and has enjoyed uninterrupted health up to the time of her accident. About four years ago, while in a stable loft, she fell, and in descending got astride a projecting pin, which injured her very seriously. She states that her external organs of generation were greatly contused, and that it was nearly a year before she could walk much or with ease. Her master, writes: "There was great contusion of the soft parts, but a fracture I never could detect. After the fall, she was confined to her bed six months, unable to walk, and for twelve months could not labor." Although her owner is a physician, I do not understand he is a practitioner of medicine; and all will acknowledge how obscure is the diagnosis of fractures of the pelvis. Without, therefore, any reflection whatever upon his intelligence or knowledge of anatomy and surgery, the pubis or ischium, or both, may have been broken by the fall which the patient sustained, without being detected. If no fracture occurred, how account for the long confinement and inability of the patient, even to walk for months? After her recovery, she was hired out, but becoming unable to labour, she had returned home. For the past four months the catamenia have failed, and she has experienced great difficulty and irregularity in urinating. On examining per vaginam, the finger encountered a rough body projecting into that canal through a vesico-vaginal fistula, an inch and a half behind the orifice of the urethra. A sound in the bladder came in contact with a calculus. The urine was bloody, and discharged every few minutes, and could not be retained. The neck of the uterus was soft, irregular and enlarged.

Jan. 9th. A dose of oil was given, which operated well; a warm hip bath was prescribed twice a day, flax-seed tea and moderate diet.



10th. Operated at one o'clock assisted by Drs. Dugas, Means, Martin of Cobham, Shaw of Covington, and in the presence of the Medical Class. As a vesico-vaginal fistula, (so much to be apprehended in lithotomy in the female,) already existed, a groove director was passed through the urethra and fistulous opening into the vagina, and by a probe-pointed bistoury it was cut out. By the section thus made, a finger was introduced into the bladder, and with the calculous forceps, a piece of bone, coated with uric acid, was extracted. This was the foreign body projecting into the vagina, and was irregular in shape, and about three-fourths of an inch square. The bladder was now found filled with a soft calculous deposit, which would allow the blades of the forceps to close through it. After breaking up this mass, another and a larger piece of bone was felt lying behind the pubis. From its position and size, much difficulty was encountered in removing it. The urethra was incised towards the clitoris, and Dr. Dugas also attempted to dislodge it. By the finger it was fortunately thrust from behind the pubis, and then withdrawn in the forceps. This fragment was much more voluminous than the first one extracted, and resembled somewhat the body of the pubis. It was closely impacted in the position described, but the coats of the bladder felt to the finger entire. The only opening in its membranes besides the incisions, being the fistula mentioned, and which was about the size of a rifle ball. Injections were now employed to wash out the bladder, and the patient placed in bed.

The duration of this irregular, and as it is believed singular operation, was nearly an hour, and few thought the patient could so soon or so completely recover. Incontinence of urine from the free incisions in the urethra, as well as from the previously existing vesico-vaginal fistula, was certainly expected.

11th. Called in haste to the patient, at 6, A. M. Found her complaining of pain and soreness throughout the region of the bladder. Prescribed, a tepid bath, morphine, diluent drinks, and repose. In the afternoon she is easier.

12th. Doing remarkably well, even retaining the urine better than could have been expected so soon. Sat up in bed a few minutes.

13th. Is decidedly improving.

17th. Has continued to get better. Examined the bladder, and detected a calculus. Failed to remove it. Failed again on the 18th, when she was instructed to retain her urine as long as possible, and then to pass it while in the hip-bath. A calculous weighing 45 grains was thus expelled on the 20th.

30th. The tip of the finger can only be introduced into the bladder. No foreign body can be detected in it. The urine has become clear and healthy, and the patient can retain it an hour or two. She takes moderate exercise in the house.

February 5th. Has gained much flesh. Complains only of incontinence while walking. She left to-day for the country, preparatory to returning home to Alabama.

The foreign bodies extracted from the bladder in this case, were

subjected by Dr. Means, Prof. of Chemistry and Pharmacy, &c., too an analysis. The calculous mass was chiefly composed of uric acid. The pieces supposed to be bone were sawed in two, and presented a cancellated appearance, and were reduced by chemical tests to animal matter and phosphate of lime. I regret not preserving the total weight of all the matter abstracted by the operation.—*Ibid.*

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*Poisoning by Lead-shot left in a Bottle.*—An individual was seized with violent colic and symptoms of poisoning, after having drunk several glasses of liquor. Dr. Hohl, who was called to the patient, examined the liquid, and found it to be turbid instead of clear; and on pouring it out into a glass, he discovered at the bottom of the bottle two pellets of shot which had become firmly fixed and converted by corrosion to carbonate of lead. On examining them, he found only a very small nucleus of metallic lead in the centre of each: so long as the liquor was clear, no ill effects had followed its use,—these had only occurred when the turbid portion, near the bottom of the bottle, had been taken. The liquor was proved to hold suspended a salt of lead, from which the symptoms of poisoning had undoubtedly arisen. This shows that great care should be used in cleansing bottles; and that a few shot left in them may give rise to all the symptoms of lead-poisoning.—*Lond. Med. Gaz.*

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*Nitrate of Silver in Erysipelas.*—M. JOBERT recommends the application of nitrate of silver in erysipelas, in the form of ointment rather than of the caustic itself. He gives three formulæ, of various strengths, for preparing this ointment. To 32 parts of lard, the strongest ointment has 12 parts of nitrate of silver, the next has 8 parts, whilst the weakest has only 4.—*Ibid.*, from *Gazette des Hôpitaux*.

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*Experiments on Antimony.*—M. E. Millon has forwarded to the Institute a series of experiments which prove, that not only the drug remains for a long time in the system after it has ceased to be exhibited, but also that it exercises a special action on the chylopoietic organs. In the dog submitted to observation, the liver increased to three times its natural size; and one bitch took tartar emetic during five days only, and a fortnight afterwards littered several living pups in the livers of which antimony was detected in large proportions.—*Lond. Med. Times.*